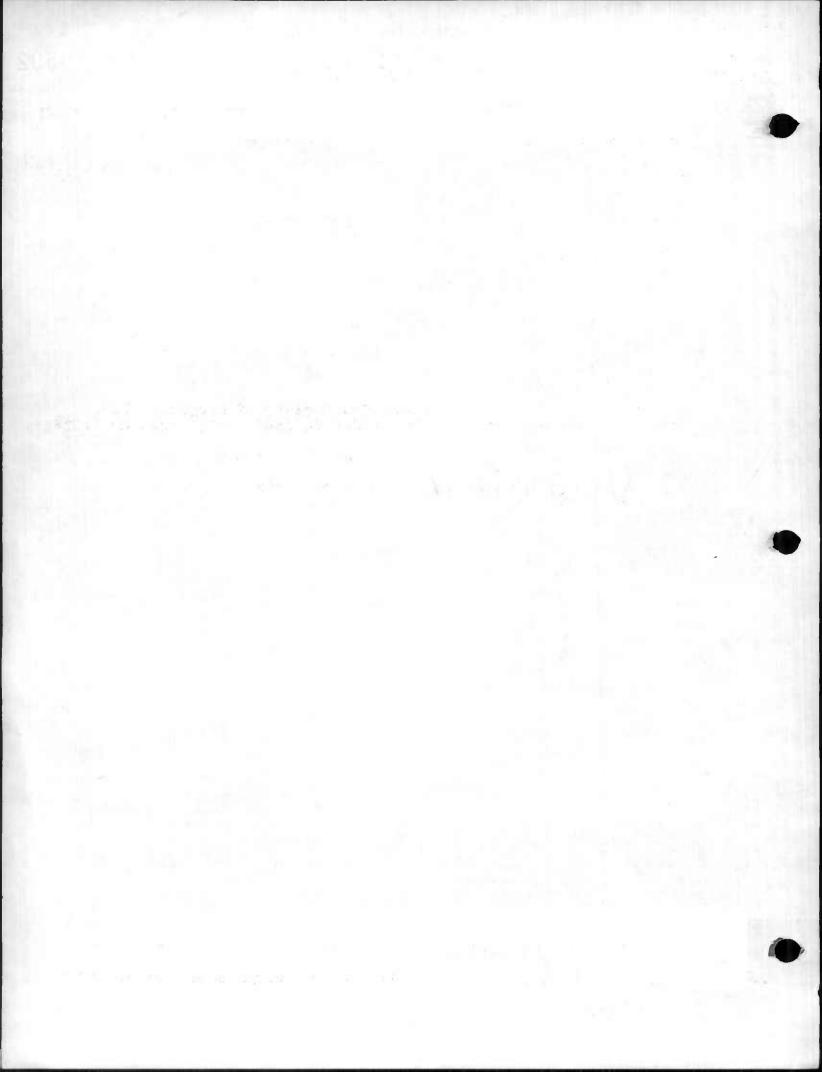
State of Maryland / Department of Health and Mental Hygiene Item 3 Per PHY Film G752 10-08-97 rja Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Mogth P.M. /Medical 4a. Facility Nama (If not institution, giva streat and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAMIMER If Undar 24 Hrs. 8, Data of 405 5. Social Sacurity Number If Undar 1 Yaar 6 Sax 7. Aga (In yrs. last birthday) Birthplace (Steta or Foraign
Country) **Funeral** Days 214-86-173 Usual Residence of Dacadant i≱M 2□ F Yrs Director Maryland 10b. County r than "natural", or itsme 23a or 28a-f show the Medical Examiner must be notified at 10d. Insida City Limits Yas 2 No MID Funeral Director 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 12. Was Decedant Evar In U,S.
Armed Forcas?

1 Yas 2 No
If Yas, Give
Yaar or Detas: 11. Marital Status Raca - Amarican Indian, Black, Whita, atc. filed within 72 hours efter Nevar Married 2 Marriad 21215-0020 Specify Completed by 3 ☐ Widowed 4 ☐ Divorced lack 15. Decedant's Education (Specify only highast grada complated) 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Heath and Mental Hygiene.
The marked other than the traumatic event, the Me College (1-4or 5+) Elamentery/Secondery (0-12) leve -0 Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be and 2 should be 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rurel Routa Numbar, City or Town, State pemii. Paga yand 2 s Department of health er Importage it item 27 is any Injury or other trau 11060 VOHNSON Ken 20b. Place of Disposition (Nama of cematary crametory or other place 20a. Mathod of Disposition Data 20c. Location - City or Town, State Pages Burial 2 Cramation 3 Ramovel from State 4 □ Donation 5 □ Othar (Spacify) 21. Signature of Funeral Service License 23a. Pant. Enter the disease, or complication and caused the death. shock, or heart feilure. List only one cause on each line. Intarval Between Onsat and Deeth **Physician** /Medical Immediata Cause (Final acknown disaasa or condition rasulting in death) Examiner Examiner The law requires that the daath certificete be axecuted usa as the bunal-tran Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury Box 68760. Physician/Medicai that initiated avants resulting in daath) Lest Dua to (or as a consaquance of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. datached 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 Unknown 1 Yee 2 No Records. ð 8 24b. Wara autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performed? certificate has been page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attanding Physician: 25. Wes casa referred to medical axaminar? Be 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) P 1 Yas 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA Division of this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: 28d. Dascriba how injury occurred After ! 5 Panding Invastigation To the Hospital or Attandir within 24 hours efter death. To the Funeral Director: Al 1 Yas the 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) filled in by 4 T Homicide 1 Certifying Physician: To tha best of my knowledge, deeth occurred at the tima, data and place, and dua to the causa(s) and mannar as steted.
2 Medical Examinar: On tha basis of axemination end/or invastigation, in my opinion, daath occurred at tha tima, dete and place, and dua to tha causa(s) and mennar statad. Medicai completely (Check only one) 29b. Signetura and titla of 29c. Licansa number 29d. Data signad (Month, Day, Yaar) m) rson who complated cause of death (Itam 23e) (Type, Print) 30. Nama and eddrass of llen 31. Data filed (Month, Dey, Year) 32. Registrar's Signatura State Tulia Davidson-Randall 0 8 1997 Registrar

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Exami	ner	2924 WINCHESTER		/				BALT				/ A	
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anyland show		Usual Residenca of Decedent  10a. Stata  10b. County		10c. City,	Town or Lo	ocation						10	od. Inside City Limits
th the M or 28a-1	Funeral Director	Maryland N/A  10e. Street and Number				10f. Zip Co		imor	ce		10g. Citizen of \	What Count	1 X Yes 2 No
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5-0020 72 hours after death with the Maryland naturel; or items 23s or 28s-f show are Examiner must be notified at	by	11. Marital Status  1   Never Married 2 Married  3   Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	os? □No 197	4-	Was Decedent If Yes, specify 1 ☐ Yes 2X		panic Orlg , Mexican, Specify:	nin? (Spe , Puerto	ecify Yes or No Rican, atc.)		e - America ck, White, e	itc.
F 6 5 8	Completed	15. Decedent's t (Specify only highest g Elementery/Secondery (0-12) 1 2	Education rede completed) College (1-4	or 5+)	(Give life.	dent's Usual O kind of work o DO NOT use r	done du retired)	iring most		ing	Manufa Plant		*
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Mary nd 2 shou lith and N 27 is mar	-	19a. Informant's Neme/Relationship									er, City or Town, timore		
is 1 and if Haalth Mem 27 other to		Veronica Johns 20a. Method of Disposition		20b. Pla		sition (Neme				Date	20c. Location -		
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/Medical Examiner	-6	Immediete Cause (Final disease or condition resulting in death)	аА	Due to (or	COTIC I		TION						
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\$ R(1)	o Be	25. Was case referred to medical examiner?  1∑ Yes 2□ No	Hospital:				Other			(Check only o			
Division of a strengthy after death. Director After the din by the funeral din by the fun	Certification: To	27. Menner of Death  1 Natural  2 Accident  3 Suicide 400 Could not	28e. Dete of land (Month).	njury Dey Year) 2 /5/97 fo	28b. Time of Injury	45 <sup>M</sup>	Injury ( Work?	4 LI NUI	10 u	28d. Describe Inknown	denca 6 □Oth how Inju <i>r</i> y occur	red	
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To the Hospital within 24 hours a To the Funeral complately filled	Medical		miner: On the basis and manner	s of examination	on and/or inv	estigation, in	my opi	nion, deati	h occurre	ed et the time,	dete and place,	and due to	tha cause(s)
) 7		30. Name and address of person who	J. Chr	A MA	23a) (Tune		o.c	.M.E.		C	CTOBER		
St	ate	Dennis J Chw 31. Date filed (Month, Dey, Yeer)	te, No	strar's Signatu	1		n S	treet	., Ва	altimor	e, Mary	land :	21201
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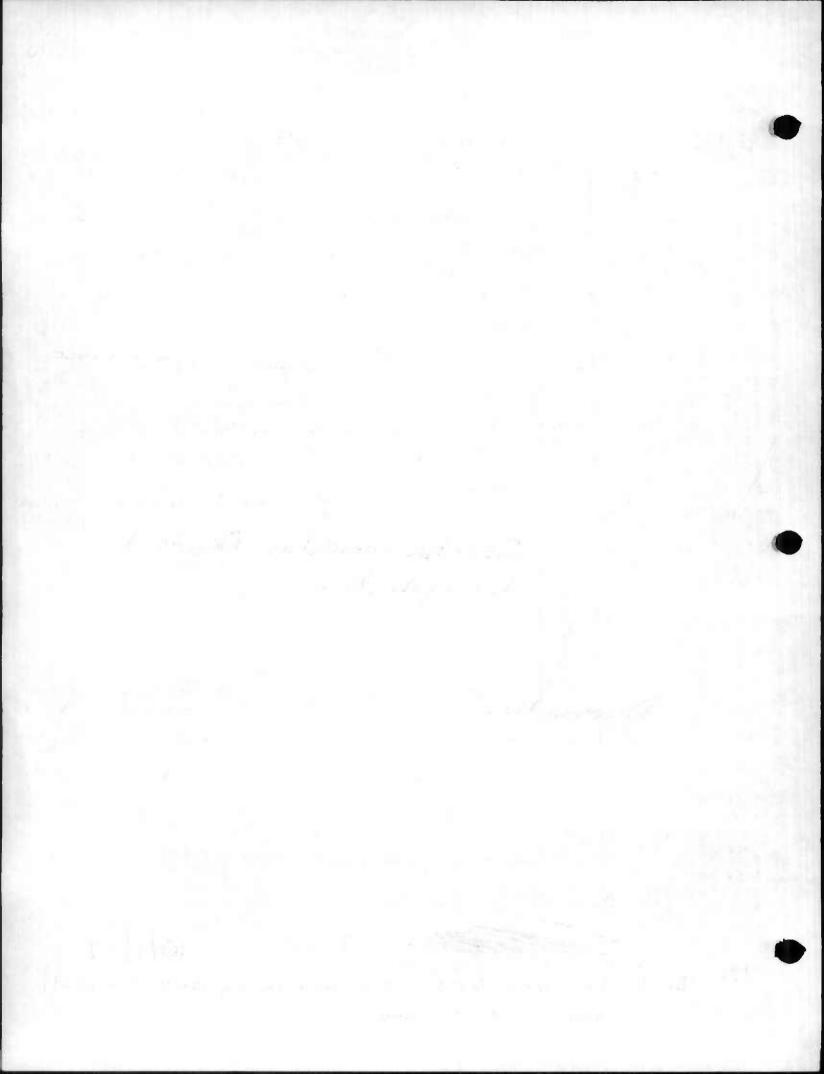
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Daath **Physician** HARRY J. JENKINS 28, 1997 SEPT. 4:31 am /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** GOOD SAMARITIAN HOSPITAL RALLIMOKE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (Stete or F. (Month, Dey, Year) | 11 A X Y L A N D 5. Sociei Security Number 7. Aga (In yrs. lest birthday) 9. Birthpiaca (Stete or Foreign **Funeral** 1₩ M 2□F 219-01-9344 35 Yrs Director Usuai Rasidance of Dacadant 10a. State 10b. Count 10c. City, Town or Location 10d. tnsida City Llmits 28a-f show must be notified at 1 Yas 2 No MARYLAND BALTIMORE Director 10e. Streat and Number 10f. Zip Code 10g. Citizan of What Country? ò 5802 NORTHWOOD DRIVE 21212 items 23a USA 12. Was Dacadant Evar in U,S Armed Forcas? Was Dacadant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black, Whita, atc. Pages 1 and 2 should be filled within 72 hours after name of Health and Mental Hygiena.
mr: n nem 27 is marked other than "natural", or ite 1 ☐ Yas 2€ No if Yes, Giva Yaar or Datas: 1 Navar Marriad 2 Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by Specify: BLACK 3 ☐ Widowad 4 ☐ Divorced Completed traumatic event, the Medical 16a. Dacadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacadant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) md. Dry Dock 6TH GRADE SHOP STEWARD 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) AAAAI JENKINS 14 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) perper Pages 1 and 2 department of Health s important: if new 27 is any injury or other tra once. 5002 NORTHWOOD DR., BALTIMORE, MD 21212 ca of Disposition (Name of Data Data 20c. Location - City or Town, State ELEANORE JENKINS/NIFE 20b. Piaca of Disposition (Neme of cametery, cremetory or other place) 20a. Mathod of Disposition 1 € Buriel 2 □ Cramation 3 □ Ramoval from State WOODLAWN CEMETERY 10/2/97 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Addrass of Facility 21. Signature of Funeral Service Licenses UNITY FUNERAL HOME 108 W. NORTH AV, Md. 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death vascular Decident **Physician** /Medicai immediata Causa (Final disaasa or condition resulting in daath) Examiner Examiner GVCV The law requires that the death cartificate be axecuted and -trans Sequantially list conditions, if any, laading to Immadiata cause. Enter Underlying Ceuse (Diseasa or Injury that Initiated avants rasulting in death) Lest Due to (or as consequence of): attanding physician a for usa as the burial-Box 68760. Physician/Medicai Dua to (or as a consequence of): P.O. | ed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown signed b Records, þ been signal 24b. Wara autopsy findings evaliable prior to completion of cause of deeth? Completed 24a. Was an eutopay page 2 2 No 1 Yes 1 ☐ Yas 2 ☐ No certificate Division of Vital Be 25. Was casa referred to medical 26. Placa of Daath (Check only one) Other: 4 "Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ER/Outpetient 3 ☐ DOA 0 1 Yas 28 No this 28a. Data of Injury (Month, Dey Year) 27. Menner of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury et Work? Alter 5 Panding invastigation 1 Neturei 2 Accident 1 ☐ Yas 2 ☐ No 6 Could not be determined 3 ☐ Sulcide 28e. Place of tnjury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida within 24 hour 29a. Certifier Certifying Phyelctan: To the bast of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of axamination end/or invastigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signeture end titia of containing 29c. Licansa number 29d. Data signed (Month, Dey, Year) 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

State Registrar

31. Date filed (Month, Dey, Yeer) OCT 0 8 1997

3007 E. Northern Parkway · Ziad K. Mirza Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

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neral rector		5. Sociel Security Number 220-62-4837 Usuel Residence of Deceden		Sex 1 □ M 2 💢 F		yrs. lest birthdej 90 Yrs.	y) If Under 1 Y Months D	eer If Unda	er 24 Hrs. Min.	8. Dete of Birt (Month, De Oct. 12	, 1906	9. Birthp Cour	place (Stete or Foreignty) aryland
ч		10e. State 10b. Cou	inty		100	. City, Town or I	Location					1	10d. Inside City Limit
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Registrar

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1. Decedeni's Name (First, Middle, Last)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Dete of Death

Month

Day

30505

3. Time of Death

24b. Were autopsy findings available prior to

completion of cause of deeth?

1 ☐ Yes 2 ☐ No

24a. Was an autopsy performed?

INSPECTION 1□ Yes 2₺No

/Mec		ANNAE	BELLE	MARY	KIN	IG					SEPT.	26,	1997		10:40 PM.
Exam		4e. Facility Name (	If not institution, gi	ve street end nu	ım <i>ber)</i>				4b. City, To	own, or Lo	ocation of Dea	th 4c	. County	of Deeth	
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D .		Usual Residence of													
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P # E	by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 ☑ Widowed	ied 2 Married	12. Was Dec Armed Fo 1 Tyes If Yes, Gi Year or D	orces? 2 🖾 No ive	in U,S.	13. Was Dece If Yes, spe 1 \(\superstack \text{Yes}\)				ecify Yes or N Rican, etc.)	0-		k, White,	
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2 sho and is me	1	19a. Informant's No	ame/Relationship	(Type, Print)		19b. N	Mailing Addres	s (Stree	t and Numb	er or Rure	el Route Numi	ber, City	or Town,	State, Zi	p Code)
E = 0 -		Harry Ki	19/Son			315	S. Ma	dier	a Str	eet.	Baltim	ore. I	Md.	7123	1
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Programme Mary or			☐ Cremation 3 [ 5 ☐ Other (Speci		State		in Ceme			9/30	/97	Bas	ltimo	re.l	Md.
important: if item:		21. Signature of Fu	Lane .	2/2	Bue	1	22. Name a	nd Addr	ess of Facili	ity Inc.	1901	East			
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/Medical Examine		Immediate Cause ( disease or condition resulting in death)	Finel n	a. Arte			c Card		scula	r Dis	sease				
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at the	5										1 [	Yes 2	2□ No	3 Pro	obably 4 Unknow

Ph The lew requires that if sion of Vital Records, by Be Completed 10 Medical Certification:

25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpalient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Injury

27. Manner of Deeth 5 Pending investigation 1 XNatural 1 Yes 2 No 2 Accident

6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homleide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29c. License number 29d. Date signed (Month, Dey, Yeer) O.C.M.E. SEPT. 27, 1997

Name and address of person who completed couse of death (Item 23a) (Type, Print)

J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

Registrar

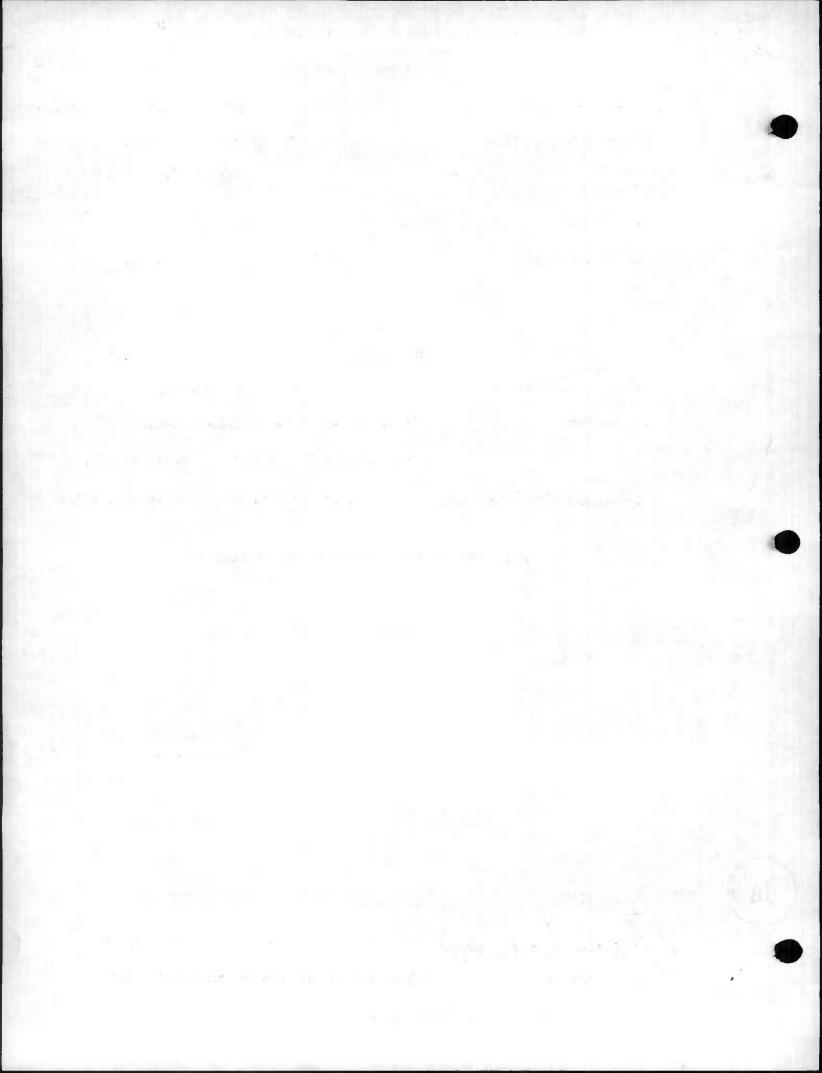
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1 XYes 2 No

31. Date filed (Month, Day, Year)

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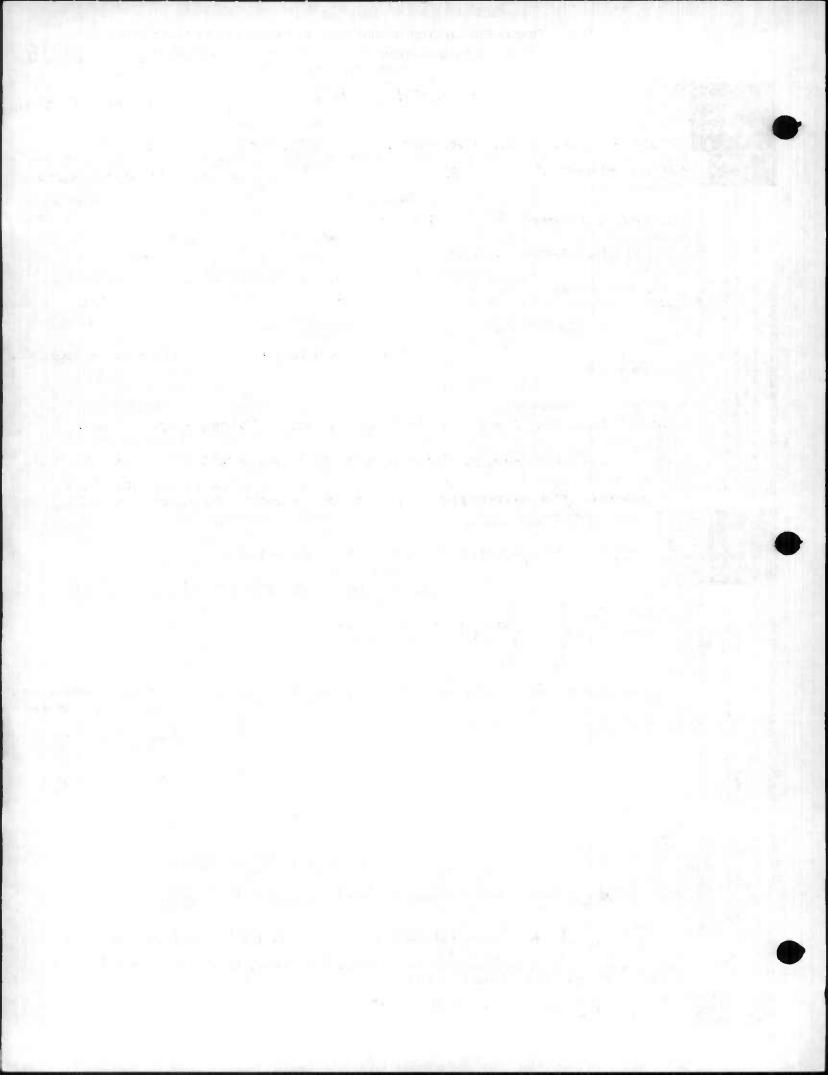




State of Maryland / Department of Health and Mental Hygiene 97

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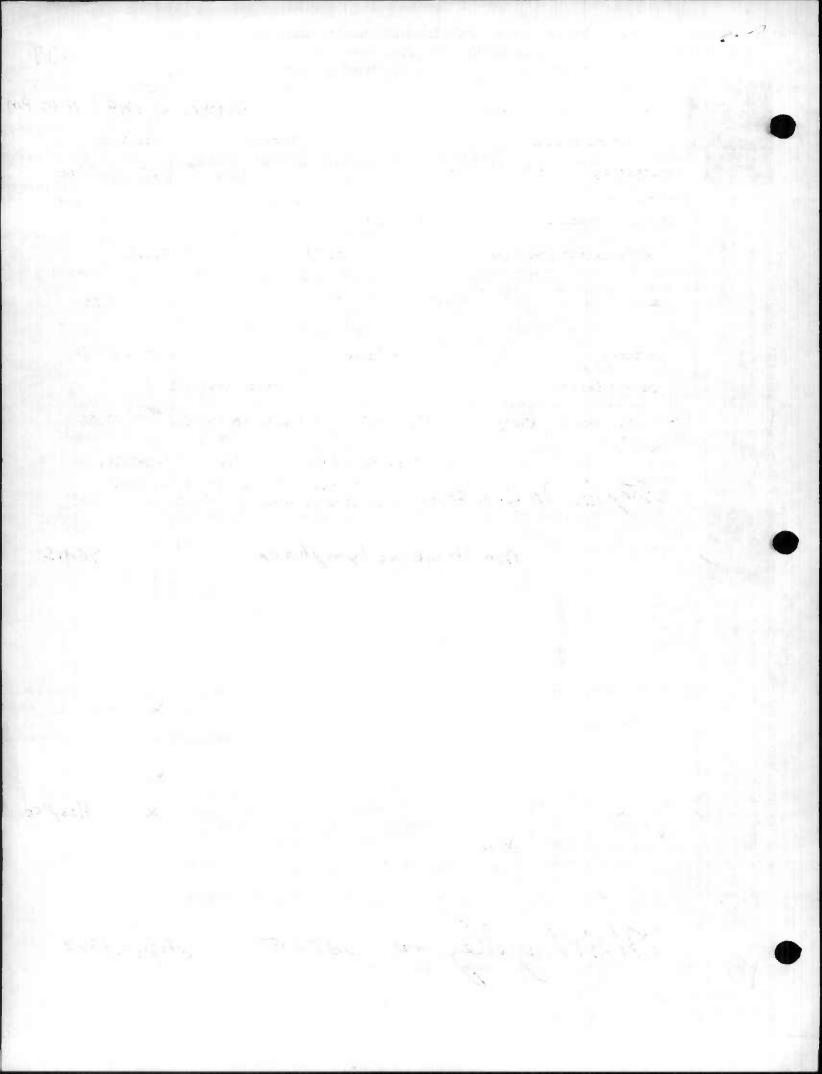
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Physicia /Medic		1. Decedent's Name (First, Middle, Le FRANK	ist)	KRUS	SHENS	KY.	2. Deta Noni	of Daath b C	3 K	Year 7	3. Time of Death H · 35 A
Examine		4a. Facility Name (If not institution, gire				4b. City, T	own, or Location of	Death 4	c. County o	f Death	
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Funeral Director		501-09-2642	Sex 7. A	Aga (In yrs. last	Yrs. R Undar Months			of Birth th, Dey, Yea 30, 1			ca (Stata or Foreign () Dakota
pue .		Usuel Residence of Decedent  10a. Stete 10b. County		10c City To	own or Location					404	t to the Oil of the
sto at	20	Maryland Baltimo								100	I. Inside City Limits  1 ☐ Yes 2 🕱 No
28a-f show	ect	10e. Street end Number	Te	Dalt	imore	Ondo		40- 6	201 - 4 200		
23s or ust be	Funeral Directo	500 Virginia Av	enue Apt	. 911	10f. Zip	21286		log. C	U.S.		/ *
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Scal Ex	ted	15. Decedent's E	ducetion	16	Se. Decedent's Usua	el Occupetion	512 - 30 -	16b.	Kind of Busi	iness/Indus	stry
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27.1		Darrell Krushen	sky / son		1569 Cott	age Lane	Towso	n, Ma	ryland	1 212	86
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V		30. Name and address of person who 8720 Emgle	completed ceuse of Rol Ba	deeth (Item 23e	(Type, Print) S	(REES)	234	PUR	ANE	EN/	
State Registra		31. Dete filed (Month, Day, Year)	32. 19	Jan de	-Randelle						



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			111111			ertificate of		F	leg. No.	30301
Physic	ian	1. Decedent's Name (First, Middle						2. Date of Dee	Day	3. Time f th
/Medi		Richard Edw						Uctobe		97 11:05 PM
Exami	ner	4e. Fecility Neme (If not Institution					4b. City, Town, or		4c. County o	
		Gilchrist Ce				Manager de Manager	Towson			imore
Funeral Director		5. Sociel Security Number 723-05-9963 Usual Rasidence of Decedent	6. Sex 7. Ag 1⊠M 2□F	e (In yrs. le:	Yrs.	y) If Under 1 Year Months Deys		(Month, Dev	, 1927	9. Birthplace (State or Foreign Country) Michigan
show		10a. Stete 10b. County		10c. City,						10d. Inside City Limits
Me Ma	cto	Maryland Balti	more		Rand	allstown				1 ☐ Yes 2 ☐ No
th with th	al Director	10e. Street end Number 8621 Allens	wood Road			10f. Zip Code 211	.33	1	U.S.A	
Laryland 21215-0020 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumatic event, the Medical Examiner must be notified at	/ Funeral	11. Maritel Status  1 Never Married 2 Married	12. Wes Decedent Armed Forces?  1 (XYes 2   1 (XYes, Giva Yeer or Dates:	Ever in U,S	. 13	B. Was Decedent of If Yes, specify Cut		specify Yes or No- to Rican, etc.)	14. Raca Biack Specify:	- American Indian, , White, etc.
hours hours	ed by	3 XWidowed 4 Divorced	Year or Dates:	1948	16a Dad				16b. Kind of Bus	White
Maryland 21215-0020 d.g. should be filed within 72 hours aft th and Mental Hygiene. 7 is mericed other than "natural", or traumatic event, the Medical Exert	Completed	(Specify only highes Elementary/Sacondary (0-12)	College (1-4or	5+)	(Git life	edent's Usual Occu ve kind of work done . DO NOT use retire :fighter	during most of wo	rking		ore City
D High		12 Years 17. Father's Name (First, Middle, I			rire	righter	18. Mothar's Na	me (First, Middle,		
d be ontal	o Be	Joseph Lenno	· ·					ta Branz		
Maryla  Listonial  Tismerke  traumatic	10	19a. Informant's Name/Ralationsh			19b. Ma	iling Addrass (Stree				Stata, Zip Code)
₹ 25 E		Brian E. Lennon	(SON)			pril Poir				77356
유트		20a. Method of Disposition		20b. Pla	ce of Dis	position (Neme of rematory or other ple	Ţ	Date		City or Town, State
Page 1		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc				w Mem. Pa		10/6	Sykesvi	11e. MD
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The lew ate has page 2	mo							1□ Y	as 2 No	1 ☐ Yes 2 ☐ No
Vital I	0	25. Was case referred to madical					26. Place of Da	ath (Check only or	ne)	
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N THE C	Certification:	3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place of Inj	ury - At hom c. (Specify)	a, farm,	street, factory, office	i i	28f. Location (S City or Tow	itreet end Numbe n, State)	r or Rurel Route Number,
To the Hospital of within 24 hours a To the Funeral D completely filled in the Funeral		29a. Certifier 1 ☑ Certifying (Check only 2 ☐ Medical F	Physician: To the best examiner: On the basis o	of my knowl	edga, de	ath occurred at the t	ima, deta end place	a, and due to the d	euse(s) and men	ner as stated.
the H hin 24 the F	Medical	one)	and manner st	ated.	- Carlo/Of					
To Vit		29b. Signature and file of certifier	1 01	/		29c. Licen	nse number			(Month, Dey, Year)
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15		30. Name and address of parson v	vho completed cause of	les in (Item 2	Зе) ( <b>Т</b> ур	e, Print)	P	2	6 - 3	1997
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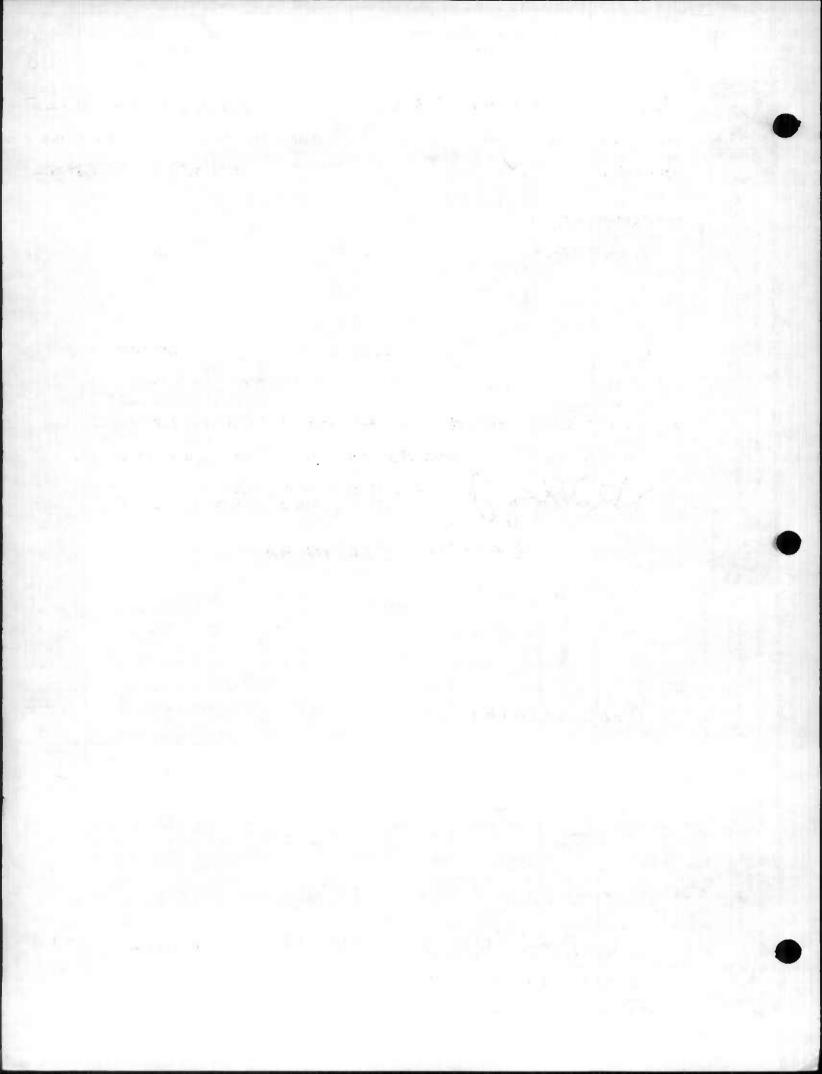
State of Maryland / Department of Health and Mental Hygiene 30508 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth LANSBERG Month **Physician** EDNA 0725 OCTOBER7, 1997 /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth
BALTIMORE Examiner NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth Month, Day, Year) 17 7. Age (in yrs. lest birthday) 9. Birthplece (Stete or Foreign **Funeral** 1 M 2 F Months Deys Hours Pennsylvania 206-03-4219 80 Yrs. Director Usual Residence of Decedent with the Merylend 10b. County than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Funeral Director Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21215 4221 Nadine Dr. death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Yeer or Dates: 11. Marital Status Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Completed by Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Seamstress Clothing other traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Peges 1 and 2 should be nent of Health end Mental Int. If Item 27 is marked of Charles Wright Minerva Knipple 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Stanley Trivas (Administrator) 3507 Gardenview Rd. Baltimore, Maryland 21208 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from State Depertment in important: If any injury or Grandview Cemetery Oct. 11 Cambria Co. Pa. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Liga-22. Neme end Address of Fecility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 Inter the mode of dying, such as cardiac or respiratory errest, 23a. Pert1. Enter the disease, or complications that daysed the death. Do not enter shock, or heart failure. List only one cause and ach line. Approximete Intervel Between Onset end Deeth Physician GASTRIC /Medical Immediate Cause (Final CARCINOMA diseese or condition resulting in death) Examiner Due to (or es e consequence of): Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest pue Due to (or es a consequence of): P.O. Box 68760, Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown COAGULO PATHY Division of Vital Records, Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? After this certificate hes 1 Yes 2(DNo 1 Yes 2 No Hospital or Attending Physician:
 Anors the dath.
 Funeral Director: After this carificaleled integral Control. Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 Po Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 27. Manner of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 D Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner steted. edicai 29a. Certifier (Check only To the To the 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 7, 1997 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) NHC, BALTO- MD 21133 . NAVI Mp. 31. Dete filed (Month, Dey, Yeer) 12. Registrar's Signeture Fully Davidson-Randell

DHMH 16 Ray 6/95

State

Registrar

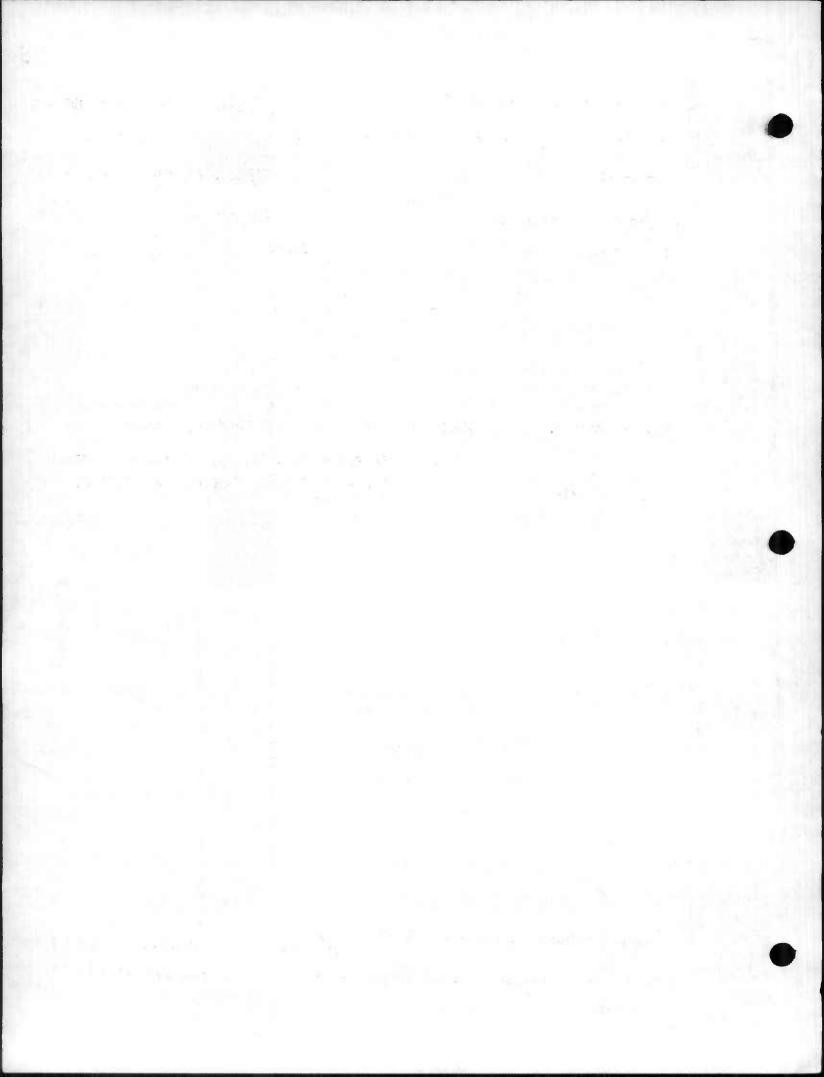


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Physicia /Medic		1. Decedent's Neme (First, Middle, La Edwin Lutte	er schi	midt						2. Dete of De Month OCTUBE	Dey	Yeer 997	3. Time of Death
Examine		4e. Fecility Name (If not institution, given Johns Hopkins Bau	re street end num	nber) Nedica	i cen	ter		4b. City, Tow Bal	m, or Loca				nore
Funeral Director		5. Social Security Number 6. S 203-16-6175			lest birthday) Yrs.		er 1 Year	If Under 2- Hours	Min.	B. Dete of Bird (Month, De Dec. 2	th y, Year) 9, 1924	9. Birth Cou Per	plece (Stete or Foreign ntry) LNS YLV ania
for death with the Maryland Herre 23s or 28a-f show ner must be notified at	ector	1.00 05 000.00	ltimore	10c. Ci	ity, Town or Lo				Dunc	dalk			10d. Inside City Limits 1 ☐ Yes 🛣 No
th with p	Funeral Director	10e. Street and Number 7802 Stansbury	Road			10f. Z	ip Code	2122	2		10g. Citizen of 1 United		
020 us sh	þ	11. Meritel Stetus  1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Deced Armed For 17 Yes If Yes, Give Yeer or De	ces? 2 🔲 No			edent of Fecify Cub	dispenic Origi en, Mexican, Specify:	in? (Spec Puerto Ri	ify Yes or No ican, etc.)	14. Red Ble Specify	ck, White,	can Indien, etc. White
21215-0020 d within 72 hours al plene. r then 'neturel', or the Medical Exem	Completed	15. Decedent's E (Specify only highest gri Elementery/Secondery (0-12)	ducation ede completed) Coilege (1-	4or 5+)	189. Deced (Give life. I	kind of w DO NOT	ork done use retire	pation during most ( d)	of working	7	16b. Kind of B		dustry
	To Be C	17. Fether's Neme (First, Middle, Last John Lutterschm	idt	Vike	40h Maille	an Aiddea	- /Street	Jose	phin	e Stan	Meiden Sumen gl	ne)	
Pages 1962 Sent of the Artist	200	Mrs. Mangaret A.  20e. Method of Disposition  DCBurial 2 □ Cremetion 3 □  4 □ Donetion 5 □ Other (Specia	Lutter.  Remove from S	chmida 20b.		Sta sition (Na netory or	NS bu	ry Roa co)	d D	undalk Dete	20c. Location	and City or T	21222
Danti. Departm Importa any Inju		21. Signeture of Funerei Service Licer	• •	1000		Duda	nd Addre		ral	Home o	6 Dunda		
Physician /Medical Examiner		23a. Petyl. Enter the disease, or com- shock, or heart feilure. List only Immediate Cause (Finet disease or condition resulting in deeth)	e	y o car	dial	in i	fara	ction	)		rrest,		Approximate Intervel Between Onset and Deeth 3 Nours
OX 68 760 certificate be nding physicia use as the bur	n/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last	b	Due to (	or es e conseq	uence of	):	dise	ase				20 years
that the death hed by the atterded for	Physicia	Pert II. Other significant conditions of	ontributing to dee	oth but not res	sulting in the u	nderlying	cause gh	ven in Pert I.			_/		o the cause of death?
0 8 5 B	Completed by Pi									24e. Wes	Yes 2 10 No en eutopsy med?	24b. W	details 4 Unknown  fere autopsy findings reliable prior to completion of cause death?
= = = = =	e Com	Of Manager								10	22	1	□Yes 2000
F & S E	ToB	25. Wes case referred to medical exeminer?  1  Yes 2  10  27. Menner of Deeth  1  Autural 5  Pending investigation	28e. Dete of (Month)		ER/Outpatien 28b. Time of Injury	t 3□ C	28c. Inju	ner: 4 🗆 Nurs	sing Home	(Check only de 5 □ Resided Describe I		er (Speci	W O.K
DIVISIO Hospital or Attendi 24 hours efter death. Funeral Director: A stely filled in by the fo	I Certification:	3 Suicide 6 Could not be determined	building	g, etc. (Specil				ma data 1		City or To	vn, Stete)		al Route Number,
2 5 2 5	Medical	(Check only one) 2 Medicat Example Medicat Example 29b. Signeture end title of certifier	niner: On the bas end menne	sis of examine or steted.	etion and/or inv	estigatio	n, in my o	opinion, deeth	occurred	d et the time,	dete and plece, 29d. Date signe	and due to	O the cause(s)  Day, Year)
1/1		→ EXX K NUMEMED 30. Name and address of person who ETIC K. NaKa	completed cause	of deeth (iter	m 23a) (Type,	Print)	15 1	1356 tospit	21	Balti	october more,	MD	1997
State	-	31. Para (Hod (Moarh, 1997) Year)		gistrer's Sign		K1-11	* 4JE						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dsta of Death 3. Time of Death **Physician** Month Vaai Claudis LeGrand October 1997 7:30 AM /Medical 4a. Fecility Name (If not Institution, giva street and number) 4h. City. Town, or Location of Deeth 4c. County of Deeth Examiner VA Maryland Health Care System N/ABALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | 0.8 / 3.0 / 1.9.2.9 5. Sociel Security Number 7. Aga (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 100 M 2□ F 68 Yrs. 240-40-3395 **Director** Carolina Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A BALTIMORE W Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ns 23s or 7 2818 OSWEGO AVENUE 21215 U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. TigYes 2 □ No 1 1 / 4 / 5 2 1 □ Yes 2 □ No Specify: Yeer or Dates: 7 / 1 / 5 4 1 Never Merried 2 Married þ Specify: Black 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grada complated) 18e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilega (1-4or 5+) Construction Bricklayer 8th 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 is merked off jury or other traumatic even Be Suckie Leak Lillie Rose LeGrand 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Amy Henderson 2818 Oswego Avenue, Balto., MD 21215 20a. Method of Disposition 20b. Plece of Disposition (Name of cematery, cremetory or other piece) 10/9 20c. Location - City or Town, Stete Dete 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Ramoval from State permit. Page Department of Important: If any Injury or once. Garrison Forest Vet. Cem. 4 □ Donation 5 □ Other (Specify) Owings Mills, Junaral Service License 22. Nama and Addrass of Fecility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207 nter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory strest, the distance List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Non Q Wave Myocardial Infarction 2 days disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner Failure Renal and -transit Sequentielly list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): physician a Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 65 US8 Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown Coronary Artery Disease by 24b. Were autopsy findings available prior to complation of causa of death? 24a. Wes an sutopsy performed? Congestive Heart Failure page 2 s certificate 1 Yes 2 No 1 Yas 2 No Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certifica 25. Wes case referred to medical examiner?

1 Yes 2 No Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Dinpatient 2 ER/Outpatient 3 DOA funeral 28a. Dete of injury (Month, Dey Year) 27. Menner of Desth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Diveture investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be 28e. Pieca of Injury - At homa, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homloide 29e. Certifier 1D Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and placa, and due to the cause(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(s) and mannar stated. To the I within 2 29b. Signeture and title of certified 29c. License number 29d. Dete signed (Month, Day, Year) matte P11738 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

10 N. Greene Street, Baltimore, MD

21201

State Registrar

31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture OCT 0 8 1997 Tripie Miridson Randage

Timothy Braatz

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30511 Item24a 10-8-97 FilmG752 W.H.per Doctor Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month 123 AM LOBDEZL 09 /Medical 4e. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MERCY HOSPITAL 301 ST PAUL PLACE BALTIMORE If Under 1 Yaar 5. Social Sacurity Number If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (Stata or Foraign Country) **Funeral** 1□M 20 F Days Hours 218-28-0081 Director 65 Oct. Maryland 8, 1931 Usual Residence of Dacedant the Maryland 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be northed at 1 X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3590 Dudley Avenue 21213 U. S. A. death Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yas, Giva Yeer or Detes: Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarlcan Indien, Black, Whita, atc. 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 □ Yas 2 No Specify: þ Specify 3X Widowed 4 □ Divorced White. Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry perint. Pages 1 and 2 should be filed within 1 Begann and Phalib and Mental Hygiena. Important: if tem 27 is merked other than "re my follury or other traumatic event, tra Med once. Elamentary/Secondery (0-12) Collega (1-4 or 5+) Secretary Roofing Company 12th Grade 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meldan Sumema) Thomas M. Mumford Ruth Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Steta, Zip Coda) 3590 Dudley Avenue, Baltimore, Maryland 21213 Frederick Redel (Friend) 20b. Place of Disposition (Name of camatary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Buriat 2 ☐ Cramation 3 ☐ Ramoval from State Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 9/29/97 Baltimore, Maryland 21. Signature of Funaral Sarvica Licensae 22. Nama and Addrass of Facility
Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23e. Part1. Enter the diseese, or complications that causad the death. Do not anter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onset and Death **Physician** /Medical Immediata Ceusa (Final COROWARY 6 weeks JUS LESS A disaesa or condition rasulting in death) Examiner HYPERTENSION certificate be axecuted the burial-transit Sequentially list conditions, if any, laading to Immadiate ceuse. Enter Undarlying Ceuse (Diseesa or Injury that initieted evants rasulting in daath) Last and Dua to (or as a consequence of) Records, P.O. Box 68760. attending physician Physician/Medical Dua to (or es a consequance of): 88

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Winknown

24b. Ware eutopsy findings availabla prior to complation of causa of deeth? 24a. Was an autopsy performed?

25. Wes casa rafarred to medical 1 Sepatiant 2 ER/Outpatiant 3 DOA 1 Yas 2 No

26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify)

27. Mannar of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Panding Invastigation 2 Accidant 6 ☐ Could not be determined 3 ☐ Sulcida

28c. Injury et Work? 28d. Dascribe how Injury occurred

1 Yes 2 No 28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

28f. Location (Straat and Number or Rural Route Number, City or Town, Steta)

29a. Certifiar 29b. Signatura end titla of certifiar

4 Homicide

Certifying Physician: To the best of my knowladga, death occurred at tha time, dete and place, and due to the ceuse(s) and mannar as steted.

2 Madical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and mannar stated.

Couter, MD

0 8 1997

29c. License number

29d. Data signad (Month, Day, Year)

30. Nema and addrass of person who complated cause of daeth (Itam 23a) (Type, Print)

301 STPAUL PLACE BACT, MD COSTA, MD 31. Deta filed (Month, Day, Yaar)

State Registrar

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Completed

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Certification:

Medical

signed by

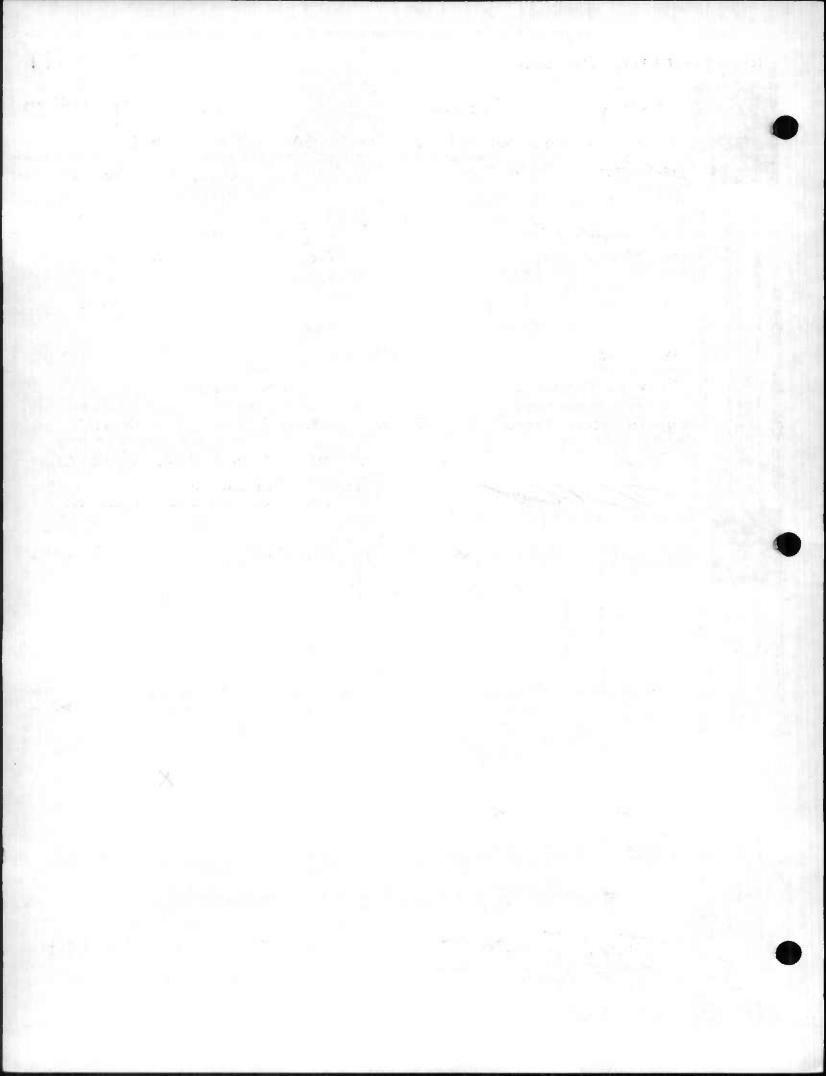
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After this certificate

To the Hospital or Attending Pr within 24 hours aftar death. To the Funeral Director: After th completely filled in by the funeral

Division of Vital

22. Registrar's Signature who Davidson Jande



State of Maryland / Department of Health and Mental Hygiene 9.7

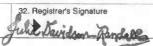
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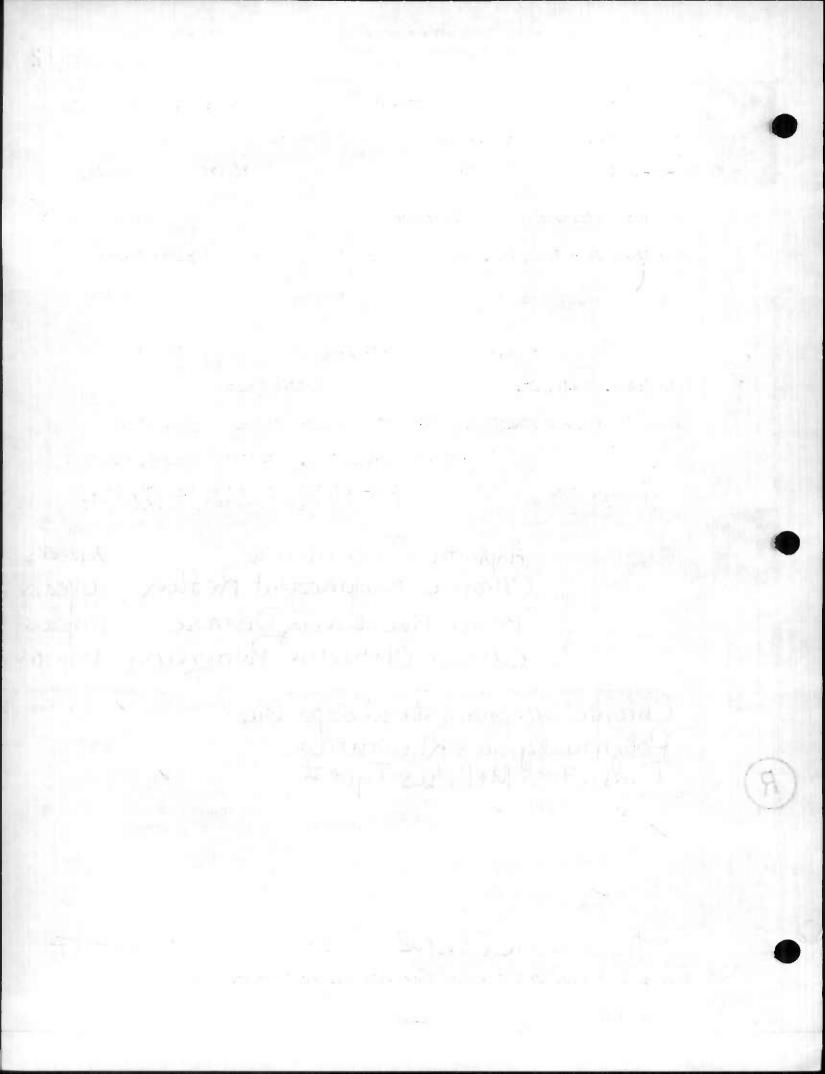
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	and		Usuel Residence of Decedent  10e. State 10b. Count	,	10c, City,	Town or Lo	cation					10d. Inside City Limits
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	r 28a	Director	10e. Street end Number		<i>J</i>		10f. Zip Cod	0		10g. Citize	n of Whet Cou	intry?
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21215-0020	hours after death with the Menyland tural; or items 23s or 28s-f show al Examiner must be notified at	by Funeral	11. Maritel Stetus  1 Never Married 2 Mar  3 XWidowed 4 Divorced	Armed Ford	No No		Was Decedent of Yes, specify C	of Hispenic Origin? ( Juben, Mexican, Pue No Specify:	Specify Yes or Norto Ricen, etc.)		Race - Ameri Bleck, White pecify: Whi	, etc.
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0_	requires that the death cer een signed by the attendin hould be deteched for use	by	Chronic	exogen	nous	steri	od d	epende	ice	Yes 2	T	obably 4 Unknow
ecords,	requir been s rould	Completed	Polymy	falgsi	ask	heu	mat	ica.	24e. Wes	an eutopsy ormed?	CC	Vere autopsy findings velleble prior to ompletion of cause deeth?
7	or, pag		25. Wes cese referred to medice	tes M	ellit	NS	IUPE	24		Yes 20	No 1	☐ Yes 2☐ No
ع	die die	o Be	exeminer? 1 Yes 2 No	Manital	patient 2□ER	R/Outpetien	1 3 DOA	Other:	eth (Check only Home 5 Res		Other (Speci	(6.1)
0	g Phys	n: T	27. Menner of Deeth	28a. Dete of		Bb. Time of	28c. Ir		28d. Describe			97
ō	Attending or death. ector: Alte by the fund	atio	1 ☑Neturel 5 ☐ Pendia 2 ☐ Accident Investi	gation	, Day rear)	injury		Yes 2 No				
Division	rs after de rs after de rs Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined   286, Piece 0	of Injury - At home g, etc. <i>(Specify)</i>	e, farm, stre	eet, fectory, office	ca	28f. Location ( City or To	(Street and I wn, State)	Vum <i>ber</i> or Rur	el Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director. Altacompletely filled in by the Tuna	edicai	29a. Certifier 1 Certifyling (Check only one) 1 Certifyling 2 Medical	ng Phyelcian: To the b Examiner: On the bas end manne	ils of examination	edge, death n end/or inv	occurred at the estigation, in m	time, dete end plac y opinion, deeth occ	e, end due to the urred et the time,	ceuse(s) er date end pi	nd menner as s ece, end due t	steted. o the ceuse(s)
	To the common	M	29b. Signeture and title of certifie	isna	Rel	re	29c. Lice D464	ense number 4558		29d. Date 8	signed (Month,	Day, Year) - 97
	Q		30. Neme end eddress of person Theresa Peet M.					l Air Mary	land 21	015		

State Registrar

OCT 0 8 1997

31. Dete filed (Month, Day, Year)

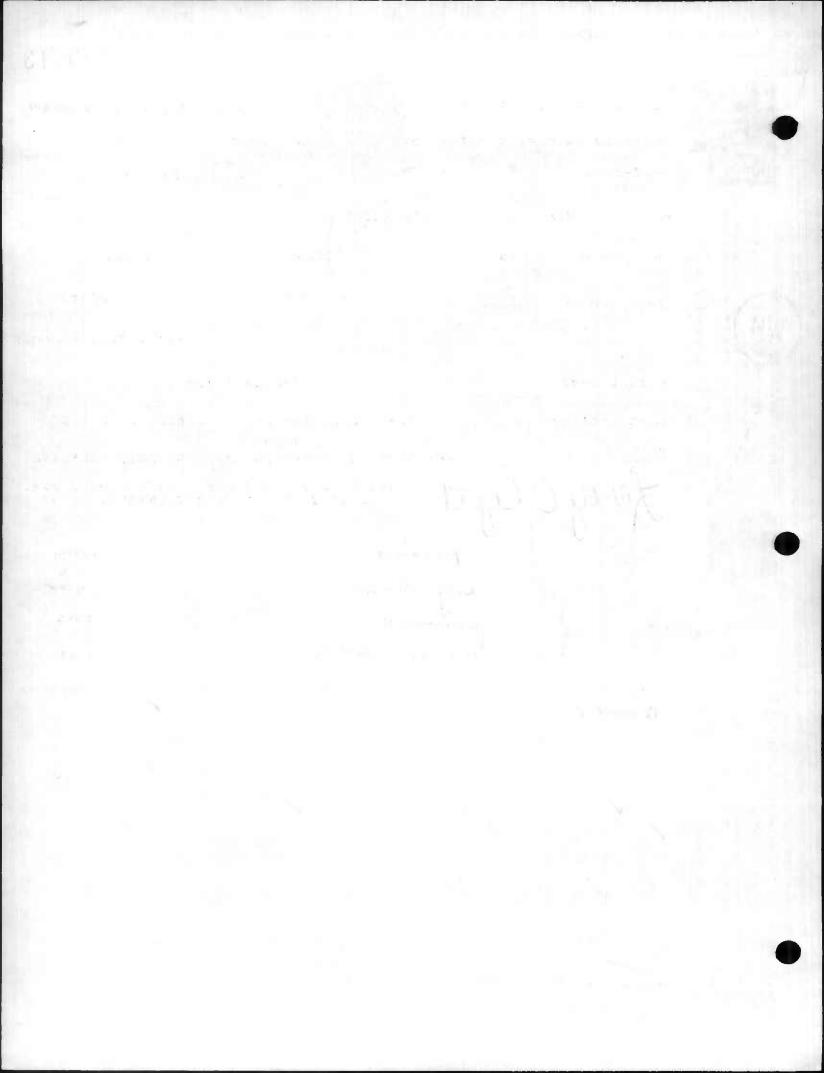




State of Maryland / Department of Health and Mental Hygiene

97

						061	uncate	UI	Dealli			Reg. No.			
sician		1. Decedant's Nama (First, A		•	VEILL						2. Deta of Da Month SEPT.	Day	Yes 199	ar	ima of Death
edical miner	4	la. Facility Nama (If not insti	ution, give	street and nu	m <i>ber</i> )				4b. City, Tov	wn, or L	ocation of Daat		county of De		
	П	MARYLAND	BAPT	IST NO	JRSING	HOME			BALT	IMO	ORE		1	N/A	
ral	1	i. Social Security Number	6. Se		7. Aga (In yrs	. last birthday)	If Under 1 Months		If Under 2	24 Hrs. Min.	8. Data of Bir (Month, Da	th Year)	9. E	Birthplaca (S	State or Foreign
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ral Director		MD	N/A			BALT									Yas 2∏No
i e	1	IOe. Street and Number					10f. Zip C	oda				10g. Citiza	an of What	Country?	
2		2801 Rayn	er A	venue					216				U.S.Z	Α.	
by Funeral		1. Marital Status  1 Nevar Marriad 2		Armed Fo 1 ☐ Yes If Yas, Gir	2 № No		Vas Daceda f Yas, specif I □ Yas 2j			in? (Sp , Puerto	ecify Yas or No Rican, atc.)		I. Race - Ar Black, W Specify:	merican Ind hita, etc. Bla	
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To Be C	11	7. Fathar's Nama (First, Mic Samuel Ca									a (First, Middla h Bole		umame)		
1		19a. Informant's Name/Rala	ionship (T	ype, Print)		19b. Mailin	g Addrass (	Street	and Numbe	r or Rur	al Route Numb	er, City or	Town, State	e, Zip Code,	)
		Janet Will	iams			3526	Lync	he	ster	Ro	ad, Ba	lto.	, MD	212	15
	2	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramat	an a 🖂	Dam aval from		Placa of Dispo cemetery, cren	sition (Name	of er pla	ce) 10	/3	Data	20c. Loca	ation - City	or Town, St	ate
8		4 □ Donation 5 □ Oth				D. NAT					PARK	LAU	REL,	MAR	YLAND
Buga		21. Signature of Funeral Ser 23a Rauf. Efter the diseas anock of heart failure.	f (	) [	Autod the dae	L 4	EROY 600 1	O.	BERTY	TT HE	& SON GHTS A or raspiratory a	VE.,		0. 2	
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cam	1 5	Sequentially list conditions,		D. — —	Duago	or as a conseq	-								
E	8	Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury hat initiated avants		c	Hype	سناء مساور	1							5	125
n/Medicai Examiner	t	that initiated avants assulting in death) Last	l	d	Dona to (	or as a consequence	wence of):	lih	u					1	48.
Physicia	P	Part II. Other significant con	ditiona co	ntributing to de	eath but not ra	sulting in tha ur	ndarlying cau	isa giv	van in Part I.				4		ause of death
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000											10	Yas 2D	No	1 🗆 Yas	2 No
Be		25. Was casa rafarrad to ma						_		of Deat	th (Check only	one)			
2		1 ☐ Yas 2 ⚠ No			-	ER/Outpatian				rsing Ho	oma 5□ Rasi			pecify)	
- Lo	2	7. Manner of Death 1 ☑Natural 5 ☐ Pa	nding	28a. Data (Moni	of Injury th, Day Year)	28b. Tima of injury		. Injui Wo			28d. Dascribe	how Injury	occurred		
Certification:		3 ☐ Suicida 6 ☐ Co	astigation uid not be tarminad	28a. Placa buildi	of Injury - At h ng, etc. (Speci	noma, farm, stra ify)	M aat, factory,		Yes 2⊡f	No	28f. Location ( City or To	Street and wn, State)	Number or	Rural Rout	e Number,
ai	2	29a. Cartifiar 112 Cart (Check only 2 Med	fying Phy cal Exami	nar: On the ba	bast of my knoasis of axaminates	owladga, daath ation and/or inv	occurred at astigation, li	tha tin	ma, data and opinion, daat	placa,	and dua to tha red at tha tima,	cause(s) a data and p	nd mannar place, and c	as statad. dua to tha c	ausa(s)
5	1	9b. Signatura and titile of ce	tifiar				29c.	Licans	sa numbar			29d. Date	signad (Mo	onth, Day, Y	'ear)
Medicai	2							1	3040	74			1110	_	
Medicai Ce		100													
Medic		0. Nama and addrass of per 4660 (v	son who co	omplated caus	a of death (Ita	m 23a) (Type,			DESA		0				



WRC 97-5697-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. JAMES R. State of Maryland / Department of Health and Mental Hygiene MATTISON Items:23a part I.27 per MEO G-752 10/27/97 dh Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month MATT 150N 05, JAMES OCT. 1997 5:03 PM. /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 400 BLK. MERYMAN BALTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplaca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days **M** 2□ F 65 Yrs. 220 24 7235 Director Usual Residence of Decedent 1∩a State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTO Mid 1 Yes 2 No Director 288-5 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? must be U.S.A ILChesler 21218 455 Norms 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No 11. Merital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify Black py 3 Widowed 4 Divorced 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) LAborer 7 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) altimore, Marylan Malloon ocephone Smith major Lo 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) Pages 1 and 2 shor 19a. Informant's Name/Relationship (Type, Print) Bulto. Md 21218 I Ochester are WILLIAMS Department of Health important: if Item 27 WANDA 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Neme of cametery, cremetory or other p Date 6 (0) T.ZION 84, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa of Funeral Servica Licensee 22. Name and Address of Fecility Locks ter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, heart fellure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final CHRONIC ALCOHOLISM disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last and the burial-trar Due to (or as a consequence of) certificate be axecu Physician/Medical Due to (or es a consequenca of): usa as P.O. signed by the signed to be datached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy completion of cause of death? certificata has Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) AT Other: 4 Nursing Home 5 Residence MXOther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 2 No this SCENE 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation **K**X Netural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 \ Homicide To the Hospital c within 24 hours at To the Funeral D completaly filled in

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and menner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) OCT. 06, 1997

Registrar

edicai

29e. Certifier

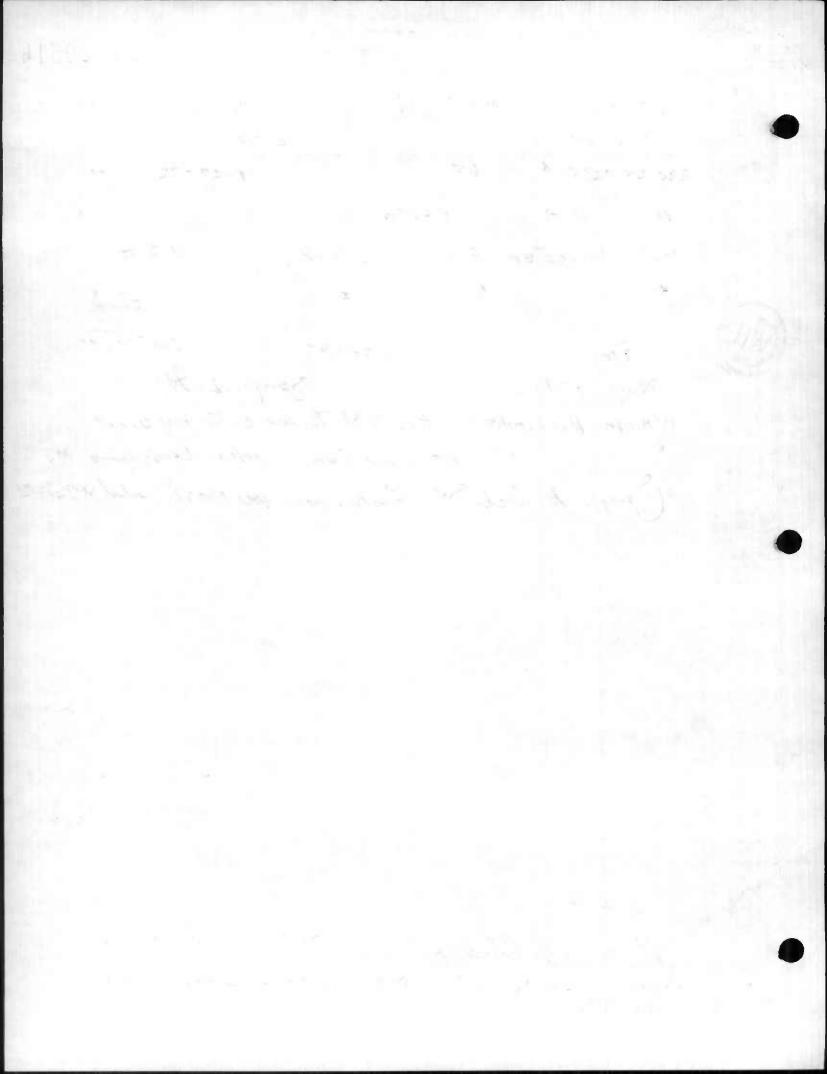
(Check only one)

29b. Signature and title of certifier

30. Neme and address of person what

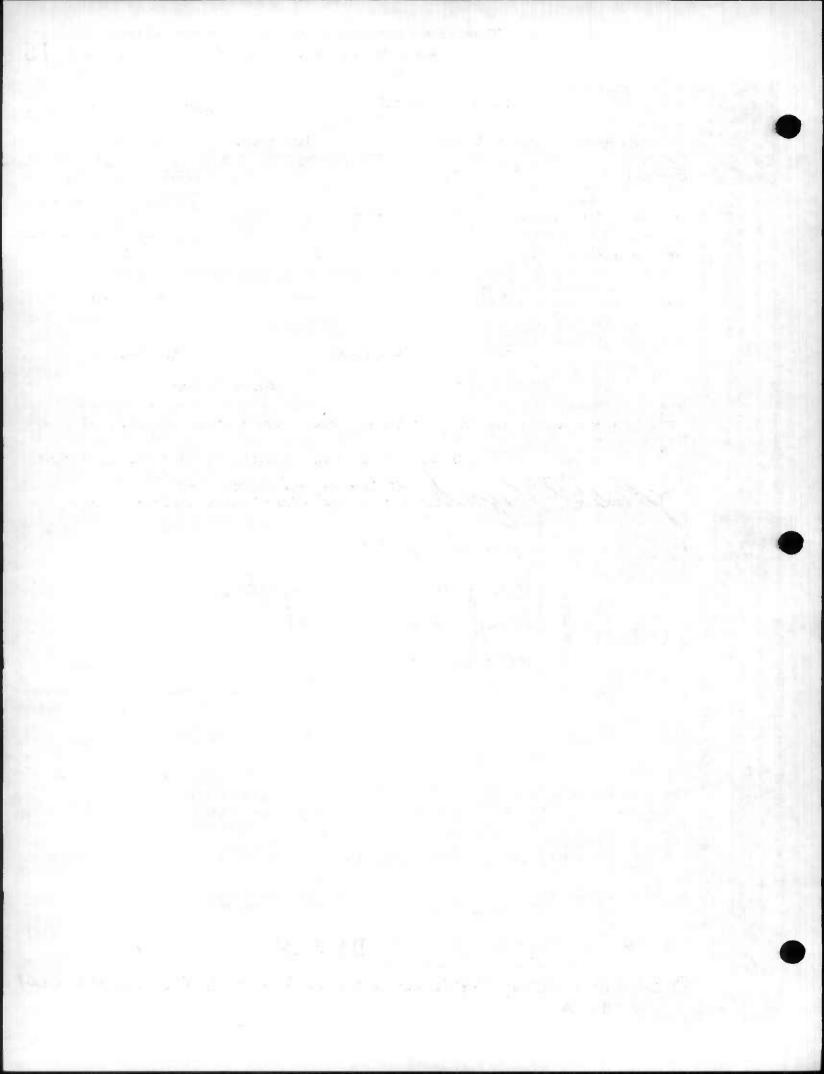
hute mo
Isa. Register's Signature
funda Davidson-fandelse 111 Penn Street, Baltimore, Maryland 21201

Churie wa completed cause of death (Item 23a) (Type, Print)



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						Ce	rtifica	te of	Death			Reg. No.			
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niner	4e. F	acility Neme (If not institu							4b. City, To	own, or Lo	ocation of Deeth	4c. County	of Deeth		
		North Arun	-			_				n Bui			e Aru		
al or	213	ciei Security Number  3-36-2633 I Residence of Decedent	6. Se	9x □M 2√∑ F	Age (In yrs.	last birthday, Yrs.	Months	Deys		Min.	8. Dete of Bird (Month, Da Oct. 22	y, Year)		place (Ste otry) ylan	te or Foreign
	10a.	State 10b. Cour			10c. Ci	ty, Town or L							1	0d. Inside	e City Limits
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al Director		Street end Number 1921 Chesapea	ke D	rive			10f. Z	p Code 21	226			10g. Citizen of	Whet Cour	ntry?	
by Funeral	1	laritel Stetus  ☐ Never Married 2 ☐ M  ☑ Widowed 4 ☐ Divorc		12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Dete	s? ☑No		Wes Dece If Yes, sp 1 Yes				ecify Yes or No Rican, etc.)	14. Rad Ble Specif	ce - Americ ck, White, y: W		1,
ete		15. Deced (Specify only high				16a. Dece	dent's Us	uei Occu	petion during mos	at of work	ina	16b. Kind of B	usiness/In	dustry	
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		Method of Disposition	Lea	gue Dat	20b. I	Piece of Dispe	sition (No	me of		LIVE	Date	20c. Location			
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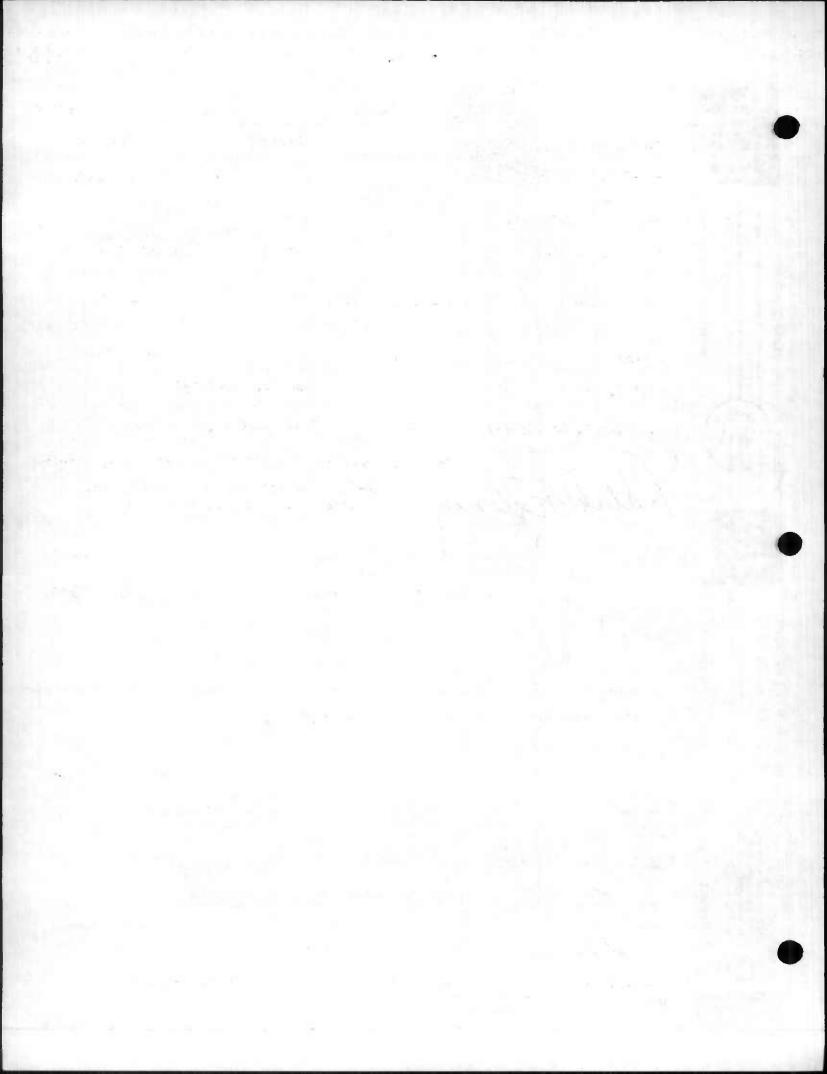


State of Maryland / Department of Health and Mental Hygiene 9.7

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			Cer	tificate of	Death	F	leg. No.	•	00010
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/Medicai		Robert	Ray N	liner	15	Octobe		97	3:28 PM
Examiner	4e. Fecility Neme (If not institution, give	e street end number)			4b. City, Town, or Lo			of Death	2007
	8516 Kavanagh Ro	and			Dundal	k	B	altim	ore
Funeral	5. Sociel Security Number 6. S	Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	1	9. Birthpie	ece (Stete or Foreign
Director	177-16-9477 Usuel Residence of Decedent	ZM 2□F 81	Yrs.	Months Deys	Hours Min.	Month, Day	6,1915		sylvania
ahow dat	10e. Stete 10b. County	10c.	City, Town or Lo	cation				10	d. Inside City Limits
or 28a-t sh be notified Director		timore			undalk				1 ☐ Yes 2 🛣 No
0 8 0	10e. Street and Number 8516 Kavanagh Ro			10f. Zip Code	21222		log. Citizen of V United		
disermast disermast Funeral	11. Maritei Status	12. Wes Decedent Ever in Armed Forces?	n U,S. 13. V	Vas Decedent of Yes, specify Cut	Hispenic Origin? (Spe ben, Mexican, Puerto	city Yes or No- Rican, etc.)		e - America k, White, e	
Exa by	1 Never Merried 200 Married 3 Widowed 4 Divorced	1 √ Yes 2 No If Yes, Give Yeer or Detes: 19		☐ Yes 2☐ No			Specify		hite
event, the Medical. Be Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16e. Decad (Give	ent's Usuel Occu	petion during most of work!	ng	16b. Kind of Bu	siness/Inde	ustry
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를 는 O	12 Years 17. Fether's Name (First, Middle, Last,		Fore	man_	10 Matheda Nama	AFTON ARTHUR			isvey
Be eve					18. Mother's Name			(9)	
70	Daniel Z. Miner				Mary M.		-		
	19e. Informent's Neme/Relationship (	Type, Print)			t end Number or Rure		-		Code)
MA	Mrs. Clara L. Mi 20a. Method of Disposition	ner/wife	8516	Kavanagh	Road Du	ndalk, 1	Marylan	d 21:	222
1111	20a. Method of Disposition  Buriel 2 Cremetion 3	Bemovel from State	<ul> <li>b. Place of Dispose</li> <li>cemetery, crem</li> </ul>	sition (Neme of netory or other pla	ece)	Dete	20c. Location -	City or Tox	vn, Stete
1	(4 □ Donation )5 □ Other (Specif	y)	Parkwood	Comotor	ry 10/8/1	997	Balti	mare.	Maryland
5 8	21. Shoulure of Ferreral Service Doer	1888	22	Name and Addr	ess of Fecility				
E E G	1 h-1 hh	1/	v	uda-Ruch	Funeral	Home of	Vundal		c.
	23a. Pert1. Enter the disease, or con- shock, or heert feilure. List only	Significant that caused the d	Bo not ente	922 Wise	2. Ave. Vu	ndalk,	MD 212		Approximate
	shock, or heert feilure. List only	one titise on each line.	7	i tio mode of dy	ing, such os cardioc c	n respiretory en	601,	1	Approximate interval Between Onset end Deeth
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be deteched for us by Physician/	Pert II. Other significant conditions of	ontributing to death but not	resulting in the un	derlying cause gi	iven in Pert i.	23b. Dld to	obacco uae coi	ntribute to	the cause of death?
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20 0	- Frances							of d	pletion of cause eeth?
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Be C	25. Wes case referred to medical				26. Plece of Deeth	(Check only or	10)		
To E	exeminer? 1 Ves 2 No	Hospitel: 1 Inpatient 2	2 ER/Outpetient	3□ DOA Ot	her: 4 Nursing Hor		1	er (Specify)	)
n: I	27. Menner of Death	28e. Dete of Injury (Month, Day Year		28c. Inju		28d. Describe h			
e funer	1 ☐ Neturel 5 ☐ Pending investigation		r) Injury		Yes 2 No				
\$ 6	3 Suicide 6 Could not be determined	286. Pieca of Injury - A	t home, term, stre	et, tectory, offica	2	28t. Location (S		er or Rurel	Route Number,
ed in by the funer Certification:	4 Homicide	building, etc. (Spe	ecify)			City or Town	n, Stete)		
to the Funeral Director: After this certificate in completely filled in by the funeral director, page Medical Certification: To Be Com	29e. Certifier 1 Certifying Ph (Check only one)	yalcien: To the best of my i	knowledge, deeth inetion end/or inv	occurred et the ti	ime, dete end plece, e opinion, deeth occurre	end due to the c	euse(s) end me ete end piece, e	nner es ste	eted. the cause(s)
Completely filled	29b. Signeture end title of certifler	end menner stated.		29c. Licen	se number	0	9d. Date signed	(Month D	lev. Yaari
F 8	) C					-	. A I I	C -	-y, 10a1)
11	La Jam	m 1			11997		19/6/	47	
X	30. Neme end address of person who	completed cause of deeth (I	Item/23e) (Type, f	Print)					
)	Edward Functionic	M.D., 1005	North Pa	nint Bl	vd., Balto	. MD	2122	4	
State	31. Detectiled (Month, Day Year)	32. Registrar's Si	queture	11				•	
Registrar	001 0 0 133/	June wouldson	- Handelle						

DHMH 16 Rev 6/95



NORMAN

30517

State of Maryland / Department of Health and Mental Hygiene	07
Certificate of Death Reg. No.	21

ACDONAL	D						Cer	tificate	of L	Death		R	eg. No.		00	017
		1. Decedent's Name (Fi	rst, Middle, Le	st)							1	2. Dete of Dee	th	.,	3. Tir	me of Deeth
Physici /Medio		Norma	an Ma	son M	ia cDo	nald						Month OCTOBE	R 6, 19	Yeer 997	6:5	OP.M.
Examin		4e. Fecility Name (If not				IIaIu			4	b. City, Towr	n, or Lo	cation of Deeth	4c. Count			01 1111
		111 TIMONIU	IM ROAL							TIMO	NTI	M	BATJ	TIMOF	RE.	
Funeral		5. Sociel Security Numb	er 6. 5	Sex		(In yrs. last	birthdey)	If Under 1	-	If Under 24	Hrs.	8. Dete of Birth	1		-	tete or Forei
Director		102-12-0146	5	M 2□ F	75		Yrs.	Months E	Deys	Hours	Min.	(Month, Dey 4-25-19			vuntry) v Yor	
9 3		102-12-0140 Usuel Residence of Dec 10a. State 10b	edent c. County			10. Oh. T										
show show	70		o. County			10c. City, To	own or Loc	ation								de City Llmi
28a-f si notified	Director		lorry			Conw	ay								Λ	Yes 2 N
8 8		10e. Street end Number		Drivo				10f. Zip Ci				1	0g. Citizen of		ountry?	
8 23 Dust	Frai		VELSILY				T		_				U.S.Z			
Ham Ham	Funeral	11. Marital Status  1 □ Never Married	2VI Marriad	12. Was De	Enrana?		13. V	Yes, specify	Cube	spenic Origin n, Mexican, F	Puerto	cify Yes or No- Rican, etc.)		eck, White	rican Indie e, etc.	en,
20.1	by F	3 ☐ Widowed 4 ☐		MAYes, G		WWII	1	☐ Yes 25	No	Specify:			Speci	ity: . V	White	
		15.	Decadent's E	ducation		16	Se. Deced	ent's Usuel C	Occupe	etion		I	16b. Kind of I	Business	Industry	
aria)	Completed	(Specify of Elementery/Seconder	nly highest gre	ede completed			(Give k	ond of work	done d retired,	fu <i>ring</i> most o	f worki	ng				
	omo	12	y (U-12)	College	(1-4or 5+	, č	uali	ty Cor	ntro	ol Dep	t.	1	Eastmar	n Koć	dak C	0.
SECTION AND ADDRESS OF THE PARTY.	Bec	17. Fether's Neme (First	, Middle, Last	)		, , , , , , , , , , , , , , , , , , , ,				18. Mother's	s Neme	(First, Middle, i	Maiden Suma	me)		
the standard	To	George		MacDon	ald					Mae		Stark				
am a		19a. Informent's Neme/	Relationship (			15	9b. Meiling	g Address (S	Street e			Route Number	r, City or Town	n, Stete, 2	Zip Code)	
104		Mrs Doris I	). MacI	bonald	(Wife	2)	127	Unive	ersi	ity Dr	ive	, Conway	7. S (	20	1526	
Them of He		20e. Method of Dispositi	on			20b. Place	of Dispos	ition (Neme etory or other	of			Dete	20c. Location	- City or	Town, Ste	te
100		1 ☐ Burial 2 🛣 Cri 4 ☐ Donation 5 ☐			n Stete			ervice			1	0-8-97	Towsor	n, Ma	aryla	nd 21
Party S		21. Signeture of Funera	Service Lice	nsee		2	22.	Name end /	Addres	s of Fecility				1050	Vor	k Rd.
90278		Wall	ace _	CRI	moh	2.91	Ru	ck Tow	sor	Fune	ral	Home,	Inc.			Md. 2
		23a. Pert1. Enter the di shock, or heert fail			caused t	he deeth. D	o not ente	r the mode o	of dying	g, such es ca	rdiec o	r respiretory err	est,	TOWL		dmete Between
hysician		SHOOK, OF FIGURE	ute. List only	One cause on	OOCH III				_					- 8	Onset	end Death
/Medical		Immediate Ceuse (Fine disease or condition		A	Ter	isid	med	35	er	elis i	lus.	sy pass	Dise	-	,	
xaminer		resulting in deeth)		е	D	ue to (or es	a consequ	uence of):			- 3		1/00	csc		
2 =	iner		_	NV 56	2622	DOS	t 0	vone	1	witer	. h	v. Dusc	cult	ini		
physician and s the buriel-transit	Examiner	Sequentially list condition	ons,	2	D	ue to (or es	e consequ	ienca of):	)	.,,,	9 1	11-33	7,00	7		
ician a		Sequentially list condition if eny, leeding to Immedicause. Enter Underlying Ceuse (Disease or Injury	liate													
the b	Medicai	thet initieted events resulting in death) Lest		C.	D	ue to (or es	e consequ	ence of):							_	
ding phys	Med		·	d												
				d								-			,	
the atter	Physician	Pert II. Other significent	conditions	ontributing to	death but	not resulting	In the un	derlying ceu	se give	en in Pert I.		23b. Did to	bacco use c	ontributa	to the ca	use of deat
ned by the atter												1 🗆 Y	es 2 No	3 🗆 Pi	robably	Unkno
000	d by													Tour !	Mana	men file at a
been si	etec											24a. Wes e perform		1	available p	psy findings nor to n of cause
2 50	Completed														of death?	. 31 00000
page												1 □ Y	es ZNO		1 🗆 Yes	No No
is certificate director, pag	Be	25. Wes case referred to exeminer?	medical	Manakati					la:		Death	(Check only on	Θ)			
this c	2	1 X Yes 2 No			Inpetient		Outpetient	3□ DOA	Othe	4 LI Nursi	1	ne 5 Reside			city) MO	TEL
	tification:	27. Manner of Deeth	Pending		e of Injury onth, Dey		Time of Injury		Injury Work			28d. Describe ho	w injury occu	irred		
or:	cat	2 Accident	Investigation  Could not b					М	1 🗆 Y	res 2□No						
ract	E	3 ☐ Suicide 6 [ 4 ☐ Homicide	determined	28e. Piec	ca of Injur	y - At home, (Specify)	farm, stre	et, factory, o	ffice		2	28f. Location (St City or Town	reet end Num n, Stete)	ber or Ru	rel Route	Number,

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted.

Wedical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29c. License number

29d. Dete signed (Month, Dey, Yeer)

O.C.M.E.

OCTOBER 7,1997

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) J. Laron Locke M.D.

31. Dete filed (Month, Pay, Year) 0CT 0 8 1997

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medicai Ce

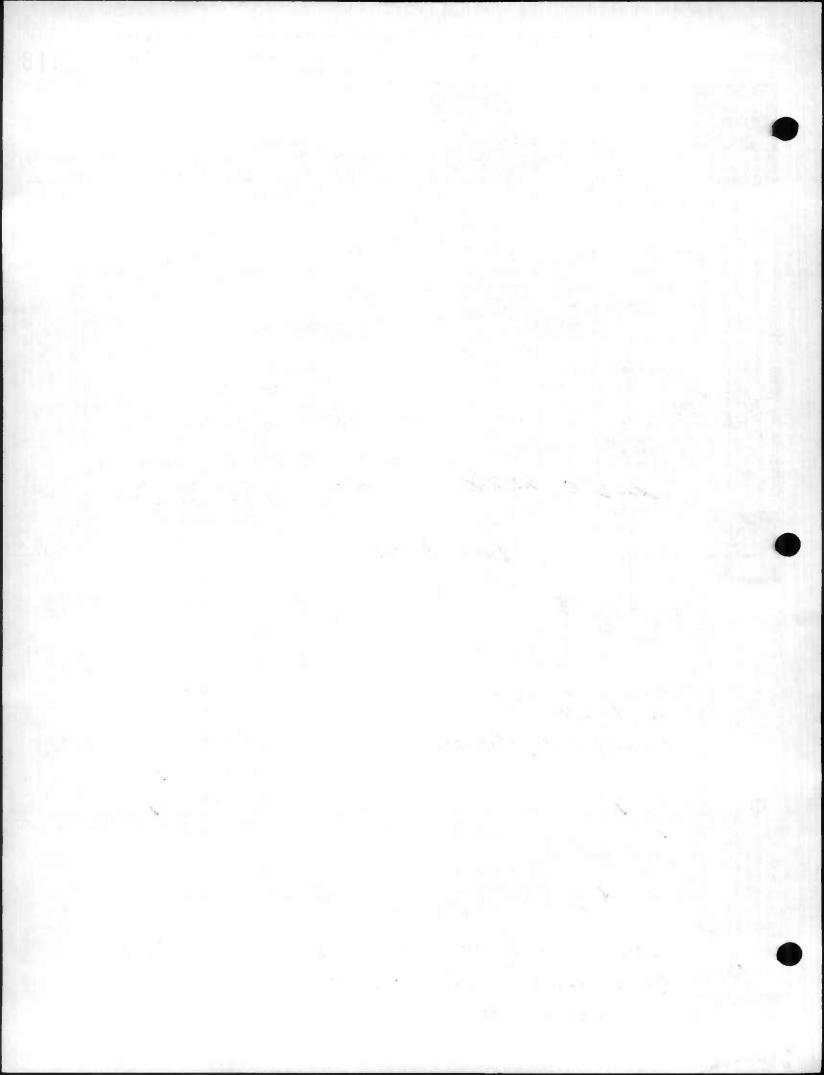
AND ENGINEER TO CONTRACTOR Michael Sylvedy is Law Device De

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97

			Certificate of Death Reg. No.											
	Physician /Medical		1. Decedant's Nama (First, Middle, Last) Francis Viles Morgan							2. Date of Month OCT	. 6, 1	Yeer   3. Time of Death   7:50		
	Exami	ner	4s Facility Name //fact in the face and a standard and as who do										ore	
	Funeral Director		5. Social Security N 215-12-7 Usual Rasidence o	548	Sax M 2DF	7. Aga (In 77	yrs. last birthday) Yrs.	If Under 1 Yee Months Days		Hrs. 8. Deta of (Month, May 2	Birth Day, Year) 2, 1920	9. Birth Cou Mar	oleca (Stata or Foreign ntry) yland	
Maryland	4 4 3 6	Funeral Director	10a. Stata 10b. County 10c. Cit				• • • • • • • • • • • • • • • • • • • •	ty,Town or Location Baltimore					10d. Inside City Limits	
đ.			10e. Street and Number					10f. Zip Coda			10g. Citizan of Whet Country?			
the state of the s		ai	2920 North Calvert St.					21218			US	A		
320 Irs after dea			11. Marital Stetus  **I Navar Married 2   Married 3   Widowed 4   Divorced   12. Was Dacadent Ever in U Armed Forcas?  1   Wes 2   Nol 944   14   15   16   16   16   16   16   16   16				944-45	If Vac enough Cuban Mayloon Duarto Digan ata			No- 14. Race - American Indian, Black, White, atc.  Specify: White			
2-0		be	15. Dacedant's Education					16a. Decedant's Usual Occupation			16b. Kind o	f Business/In	dustry	
21215-0020 d within 72 hours at		Completed by	(Spacify only highast grada complated)  Elamentary/Secondary (0-12) Collega (1-4or 5+)				lifa.	(Giva kind of work done during most of working lifa. DO NOT use retired)						
2 2			2 Fethode News (Circl Middle Local)				Clerk	Clerk			Steel Industry			
and		Be	17. Fether's Nama ( <i>First, Middl</i> a, <i>Last)</i> Gerard Morgan								a (First, Middle, Maiden Sumama)			
aryla		10	Gerard Morgan  Mary Alice Cochr  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Streat and Number or Rural Route Number, City or Town,									Codel		
, Me			Alvin J. Filbert/Friend							. Bel A			(0000)	
nore,			1 ☐ Burial 2 X Cremation 3 ☐ Ramoval from State				cematary, cra	flace of Disposition (Nama of ematary, cramatory or other place)			20c. Location - City or Town, Stata			
Baltimore, Maryland			4 Donation 5 Other (Specify) Metro  21. Signature of Funaral Service Licensea					o Crematory, Inc. 10/7/97 Baltimore, MD  22. Nama and Address of Fecility Cremation Society of Maryland, Inc.						
			Georg	e E. Mac	Nabb	caused the	10	(1) The	and all D.	I D 7 1 '	3.00	21228	Approximete	
1	after death. Director: After se conficate has been signed by the ettending physicis In by the funeral director, page 2 should be deteched for use as the bur	,	Ceorge E. MacNabb  23a. Pert1. Enter the disease, or complications that caused the death. shock, or heart fellure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or					er-		, data or recipions,			Interval Batween Onset and Death	
, mecuted		Examiner	Sequantially list co if eny, laading to in ceusa. Enter Unda Cause (Disaasa or	nditions,	b	b. Due to (or as a consequence of):								
ox 68760, certificate be executed			Cause (Disaasa or that Initiated events rasulting In daath) I		C	c								
<b>U</b> -		AU/NE	d											
ords, P.O. B.		Physician/Medical	Pert II. Other significant conditions contributing to death but not result Emphyseus								23b, Did toleacco use contribute to the cause of death?  1 Yee 2 No 3 Probably 4 Unknown			
of Vital Records,		Completed by	CONDUNITY ANTELY Disease				10.				performed? aveileble		ara autopsy findings eileble prior to implation of causa daath?	
œ 2										1[	Yas 21 N	0 1	☐ Yas 2☐ No	
ita		Be	25. Was cese refer examiner?	red to medical	26. Place of Death (Check only one)									
2 /g		2	1 ☐ Yes 2	No	Hospitel: 1									
		Certification:	27. Manuer of Death  1 Natural 5 Pending 2 Accident Invastigation		28a. Dete of Injury (Month, Day Year)  28b. Time of Injury  28c. Injury et Work?  1  Year 2 No									
5 8		Sertific	3 ☐ Suicida 4 ☐ Homicida	6 Could not datamine	28a. Place build						on (Straat and Number or Rural Route Number, Town, State)			
To the Hospital		edicai												
Tot		M	29b. Signature and title of certifier  Duvi Turif us					29c. Licansa numbar D 23855			29d. Date signed (Month, Dey, Year)			
	4		30. Nama and address of person who complated cause of deeth (Itam 23a) (Type, Print)  DANIEL FEINTAL, MD. 5820 YOME RD. BATT, MP 21212											
	Sta Registr		31. Data filed (Mont	h, Dey, Year) T 0 8 199		legistrar's S		482						

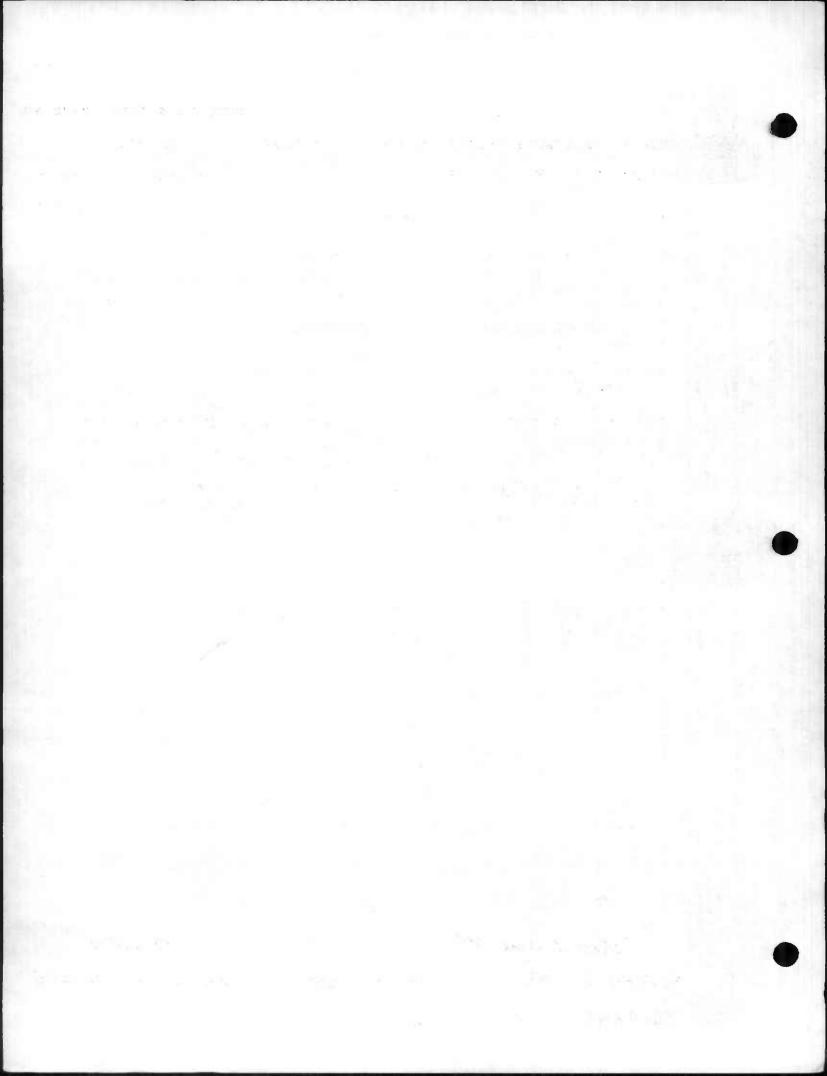


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Jay Paul Mullen OCTOBER 1997 2:42 PM /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 169-28-8305 Director SEP 10, 1935 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits 25a-f shoy r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at MD N/A Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 South Augusta Ave. 21229 death USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ② No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black. White, etc. hours after 1 Nevar Marriad 2 Married 1 ☐ Yes 2 X No Specify: P Specify:White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Industry flled within 7 Hyglens. Elementary/Secondary (0-12) 12 College (1-4or 5+) Salesman Retail permit, Pergis 1 and 2 should be file Defpartment of Health and Mental Hy Important: If Item 27 is marked oth, any injury or other traumatic event 9006s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Cornelius Patrick Mullen Esther Florence Hook 0 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine S. Mullen/wife 305 South Augusta Ave. Baltimore, MD 21229 Baltimore, 20b. Piace of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 10/08/97 Baltimore, MD 21. Signature of Funeral Service Licensee Conado
Dawn F. McDonald 22. Name and Address of Facility
MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Cause (Final disaasa or condition resulting in death) PULLIONALY EDGUA **Examiner** Physician/Medical Examiner CORONALY APTERY attending physician and for use as the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Dua to (or as a consequence of): Part Ii. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. Division of Vital Records, P.O. the detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by DEPENDENT DIABETES MELLITUS þ 2 lay requir should 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy parformed? Completed certificata has page 2 1□ Yas 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death after death.

Director: After the funeral of in by the funeral of its funeral of 28a. Date of Injury (Month, Day Year) 28b. Tima of injury 28c. injury at Work? 28d. Describe how injury occurred Certification: 1 Naturai 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide in 24 hou. the Funeral Dis-1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as atated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signature and title of certifiar 29c. Licanse number Sylun U. Byal Mo D22723 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 5 CAMPBELL BLD WHITE MALES MID 21236 4920 STEPHEN K DEAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature Luha Davidson OCT 0 8 1997 Registrar

**DHMH 16 Ray 6/95** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth Month Thomas Edward Michael OCTOBER 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth GIEN BURNIE ARUNDEL HOSPITAL FINNE ARUNDEL 8. Dete of Birth Augusth 29, Year 938 5. Sociel Security Number 219-26-9623 If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. lest birthday) 5 9 Yrs. 9. Birthplece (State or Foreign Deys Hours **™** M 2□ F Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits MD Baltimore Catonsville 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 619 Longview Drive 21228 USA 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 12 Yes 2 No If Yes, Give Korean Yeer or Detes: 1 Never Married 2 Married Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Maintenance Worker Recreation & Parks 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) William Michael Margaret Gorman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy E. Michael/wife 619 Longview Dr. Catonsville, MD 21228 20e. Method of Disposition O Buriel 2 Cremetion 3 Removel from State 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lake View Memorial Park 10/9/97 | Eldersburg, MD 21. Signeture of Puneral Service Liger 22. Name end Address of Fecility Dawn F. McDonald MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete interval Between Onset end Deeth ocardial Infuction immediate Cause (Final disease or condition resulting in deeth) Section Sequentially list conditions, if eny, leading to Immediete cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 KNo 3 □ Probably 4 □ Unknown 24b. Were autopsy tindings aveileble prior to completion of ceuse of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dev Year) 28h Time of 28c. injury et Work? 28d. Describe how injury occurred 1 Defletural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide

Examiner sician and burial-transit physician a Box 68760, 950 P.O. signed by t Division of Vital Records, After

py Completed

4 - Homicide

0

29a. Certifier

Physician/Medical Certification: edical

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Lo

Director

r than "natural", or liems 23a or 28a-f show the Medical Examiner must be notified at

2 should be filed within 73 and Mental Hygiene. In marked other than "rv

pormit. Pages 1 and 2 should be Degarment of Health and Mental 1 important: If Imm 27 is married of any Injury or other

**Physician** 

/Medical

Examiner

or Attending Faffer death. pletaly filled in by To the Hospital owithin 24 hours all To the Funeral D

State Registrar

29b. Signature and title of certifier

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

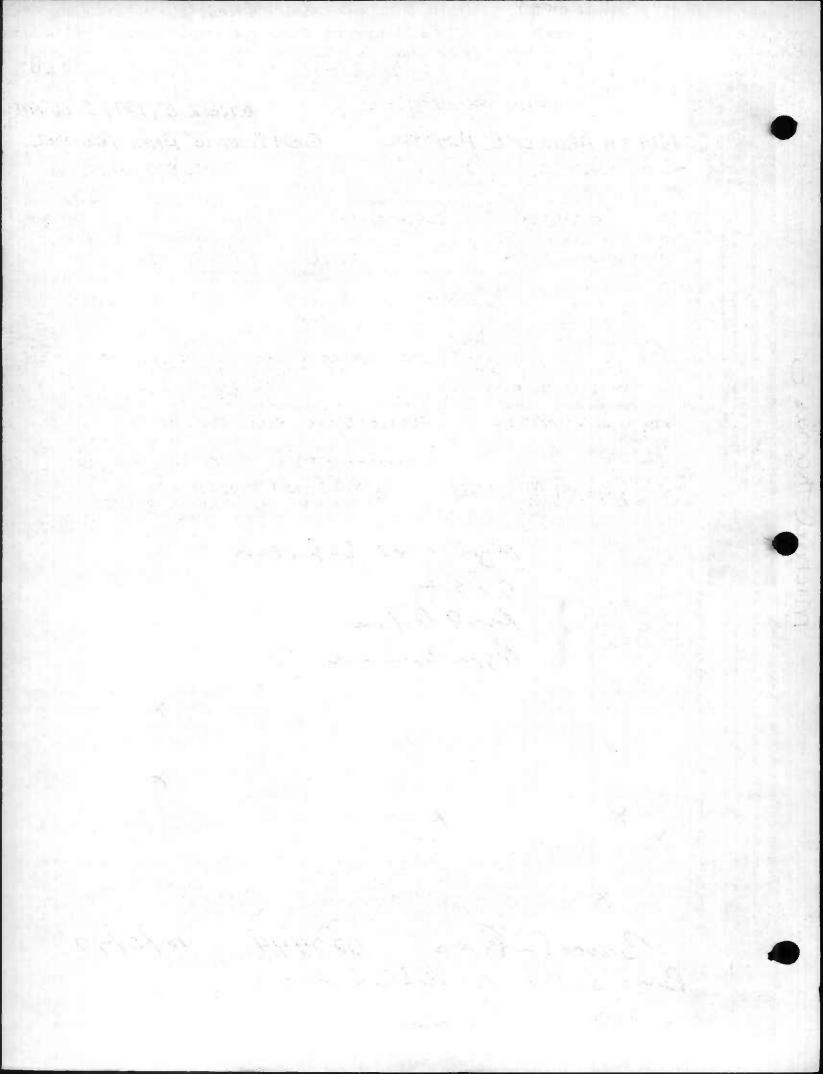
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) 1314 Bed Dr

31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

**DHMH 16 Rev 6/95** 



97-5672-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AM LUIS State of Maryland / Department of Health and Mental Hygiene 30521 MARTINEZ Certificate of Death ITEMS #1 PER MEO FILM G761 7-15-98 WR. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month OCTOBER 04, 1997 1948 P /Medical 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1408 ODESSA THOMAS CT, IN VEHICLE BALTIMORE 5. Social Security Number If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1**X**M 2□ F 583 67 /714 Usual Residence of Decedent Yes DOMINICAN RePub Director 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No New York 28a-f 10e. Street and Number 10g. Citizen of What Country? b munt be R.D 22/ therms 23a 10034 Funeral 11. Maritai Status 14. Race - American Indian, Black, White, etc. Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 à 2 No Specify: DOMINICAN þ 3 ☐ Widowed 4 ☐ Divorced natural'. Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) LABORE General 12 parmit. Fages 1 and 2 ahout be filed.
Department of Health and Mental Hygis
Important. If Illiam 27 is marked other i any Injury or other traumatic event. Its Baltimore, Maryland 17. Father's Name (First, Middle, Lest) Be KOSA LUIS DeLA 19a. informant's Name/Relationship (Type, 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Ros A-Brother #503 221 5 herman 20e. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 108 WEST North Axe BAltIMORE, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner ician and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of) that the death certificate be exec 68760 the Due to (or es a consequence of): P.O. Box Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. should be d þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24e. Wes an autopsy performed? page 2 1 Yes 2 No 1 Yes 2□ No Division of Vital 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XIOther (Specify) VEHICLE 10 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Naturai Injury 10.4.97 1 Yes 2 Accident 1940 8 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) ration (Skeet end Number or Rurel Route Number, or Town, Stete) or A effer 4 Homlcide last: 1408 Od685a To the Hospital within 24 hours or 29a. Certifier Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

111 Penn Street, Baltimore, Maryland 21201

muse of death (Item 23a) (Type, Print)

uli Davidson

29d. Date signed (Month, Dey, Year)

OCTOBER 05, 1997

State Registrar 29b. Signature

30. Name and a

31. Date filed (Month Da

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DHMH 16 Ray 6/95

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month SANG OCHODER 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth NA TENERAL If Under 1 Year If Under 24 Hrs. 10 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) 6. Sex 7. Age (In yrs. lest birthday) Deys Hours tX™ 2□ F Yrs. 213-94-3450 Feb. 10, 1918 South Korea Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1213 Light St. 21230 Korea 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2% No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Never Married 2K Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Korean 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 Factory Worker Beta Shoes 17 Fether's Neme /First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Young Won Nam Un Uen Cheio 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2887 Country Lane Ellicott City, Md. 21042 20b. Plece of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete Sung Woo Nam/son 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Memorial 10/6/97 Timonium, Md. 21. Signature of Suneral Service Licensee 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset end Deeth Immediate Cause (Fine) THEUMONIA diseese or condition resulting in death) Due to (or as e consequence of): EMENTIA Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting to deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 40 Unknown 24b. Were autopsy findings avellable prior to completion of cause 24e. Wes en eutopsy of death? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 28. Piece of Death (Check only one)

**Physician** /Medical **Examiner** 

aftimore, Maryl

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show must be notified at

6 Items 23a

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Funeral

by

Completed

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The law requires that the death certificate be axecuted

certificate

Box 68760.

P.O.

Records,

of Vital

Division

Physician/Medical þ Completed Be To the Hospital or many within 24 hours after death.
To the Funeral Director: After this or managery filled in by the funeral dir 2 Certification:

1 Yes 2 No

29a. Certifier

(Check only one)

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State

Registrar

25. Was case referred to medical 27. Manner of Deeth

5 Pending Investigation 1 Neturel 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be determined

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospitel: 1 Hopatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

29b. Signeture end title of certifier

ESIDENT deeth (Item 23e) (Type, Print)

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainly as stated.

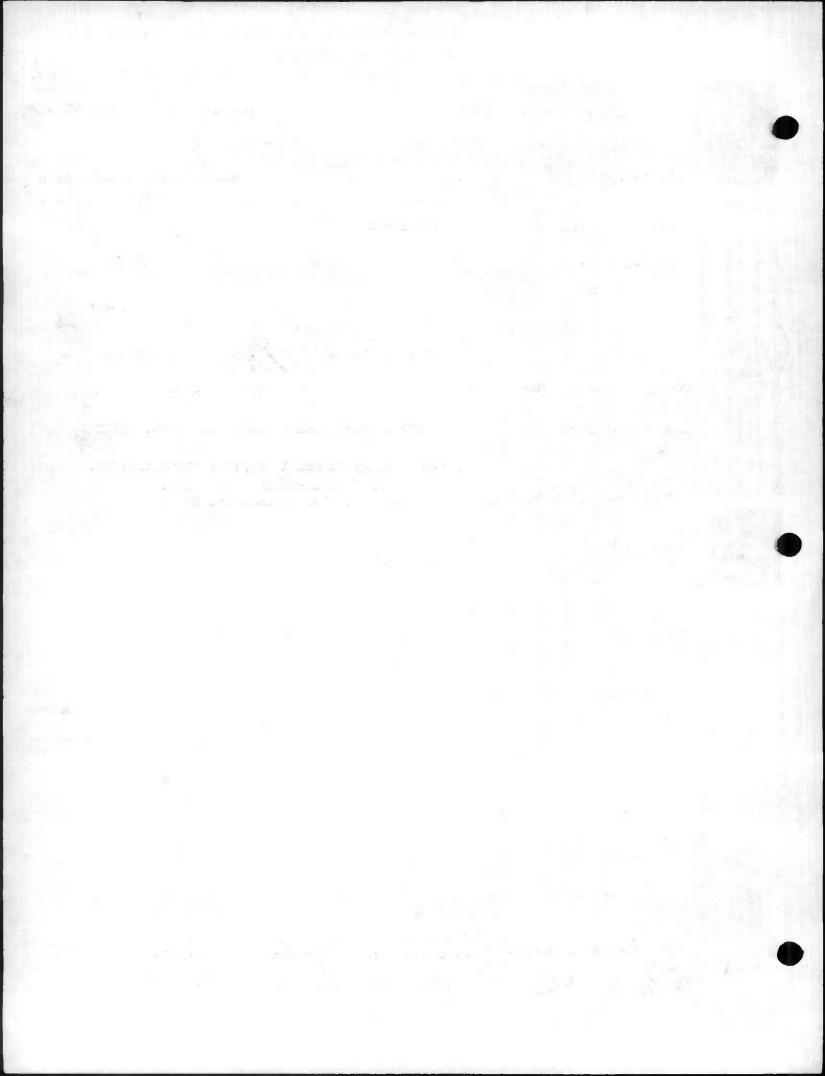
29d. Date signed (Month. Dev. Yeer)

30. Name end eddress of person who completed ceuse

31. Dete filed (Month, Day, Year) OCT 0 81997

lia Davids

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

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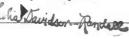
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DAREL **ANDRE OWENS** OCTOBER 05. 1997 2:09 PM. /Medical 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year Months | Days If Undar 24 Hrs. 8. Deta of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 289-58-8229 41 MARCH 18, 1956 OHIO Director Usual Rasidance of Dacedant 2 should be filed within 72 hours efter deeth with the Maryland and Mental Hygiene.
Is marked other than "natural", or Hams 23a or 28a-f ahow 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f ahow traumstic event, the Modical Examiner must be notified at 1 X Yas 2 □ No Directo MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? 3811 WOODBINE AVENUE 21207 USA. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Reca - Amarican Indien, 11. Marital Status Black, White, etc. 1 ☐ Yas 2 M No If Yas, Give 1 Naver Memied 2 Memied 1□ Yes 2 No Specify. by 3 Widowed 4 Divorced **BLACK** Year or Datas: Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER NORWEST FINANCE CO. 3 YRS. 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be CONWAY **OWENS** CATHERINE 2 19e. Intormant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 sh Department of Heelth and Important: If Itam 27 Ia m any Injury or other traum once. CATHERINE MIKE (MOTHER) 3811 WOODBINE AVENUE, BALTIMORE, MD. 21207 20e. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, State 1 XBurlal 2 Cremetion 3 Ramoval from State UNION CEMETERY 10-11-97STEUBENVILLE, OHIO 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Funeral Service Licansae JÖSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVENUE, BALTIMORE, MD. 21217 23a. PertT. Enfar the disease, or complications that caused the death. Do not antar the mode of dying, such es cardiec or raspiratory errest, shock, or heart tellura. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical Arteriosclerotic Cardiovascular Disease Examiner Dua to (or as a consequence of): Examiner ettending physician and for use as the burtal-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, laeding to immadiate cause. Enter Undarfying Causa (Disaasa or Injury that initiated evants resulting in daath) Lest Dua to (or as a consequence ot): Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Munknown à 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed peed Seu certificate 2 No 2□ No Yas relcian: 25. Was casa referred to madical axaminar? director Be 26. Plece of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) 10 18 Yas 2 No 1 Inpatiant 25 ER/Outpatient 3 DOA ö 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury et Work? 28d. Dascribe how Injury occurred Certification: sion Netural 2 Accident 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 6 Could not be detarmined 3 Sulcide 28a. Place of Injury - At homa, tarm, straat, factory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide 24 hours Hospital Land Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifiar Medical (Check only one) To the Vithin 2 29b. Signature 29c. License number 29d. Data signed (Month, Day, Year) OCTOBER 06,1997 O.C.M.E. and address of person who complated cause of death (Itam 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 J. Laron Locke M.D.

State Registrar 31. Data tiled (Month, Day, Year)

32. Ragistrar's Signature

istrar 0CT 0 8 1997



DHMH 16 Rev 6/95

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#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 1997 03 4:05 am Oct. Vivian M. Palmer 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 3600 Garrison Blvd. Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 M 2 X F Yrs. Feb 22, 1925 246-22-8670 72 North Carolina Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 to Yes 2 □ No n/a MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3600 Garrison Blvd. Apt A-2 21216 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Grade Food Server Baltimore City School 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carlton Morton Serena Withers 19a. Informent's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James W. Palmer 3600 Garrison Blvd. Apt. A2 Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Finnoval from State 4 Donetion 5 Other (Specify) Arbutus Memorial Park Oct 9th Baltimore County, MD 21. Signature of Funerel Annu 22. Name and Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy Baltimore, MD 21216 sed the death. Do not enter the mode of dylng, such as cardiac or respiretory arrest, 23a. Part 1. Enter the disease, or complications that call shock, or heart failure. List only one cause on oar Approximete Intervel Between Onset end Death IC CARCINOMA ESOPHACUS Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Lest Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24b. Were sutopsy findings available prior to 24a. Was an eutopsy completion of cause of death? a No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 2 3 No Other: 4 Nursing Home 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 8 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical **Examiner** 

Examiner

Physician/Medical

by

Completed

Be

Certification: To

**Physician** 

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be filed within nent of Health and Mental Hygiena. Int: If Item 27 Is marked other than ", Iry or other traumatic event, The Mental Page 1.

permit. Pages 1 end 2 sh Department of Health end Important: If Item 27 is m any Injury or other traum once.

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72 hours after

21215-0020

Baltimore, Maryland

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The law requires that the death certificate be axecuted buriel-tran physician s tha buriel 88 page 2 should certificate this

24 hours completely 100 within 2

Certifying Physicien: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cartifier

5 Pending investigation

6 Could not be determined

1 Alaturel 2 Accident

3 Suicide

4 Homicide

29c. License number

1 Yes 2 No

29d. Date signed (Month, Day, Year)

BALTIMORE, MD 21201

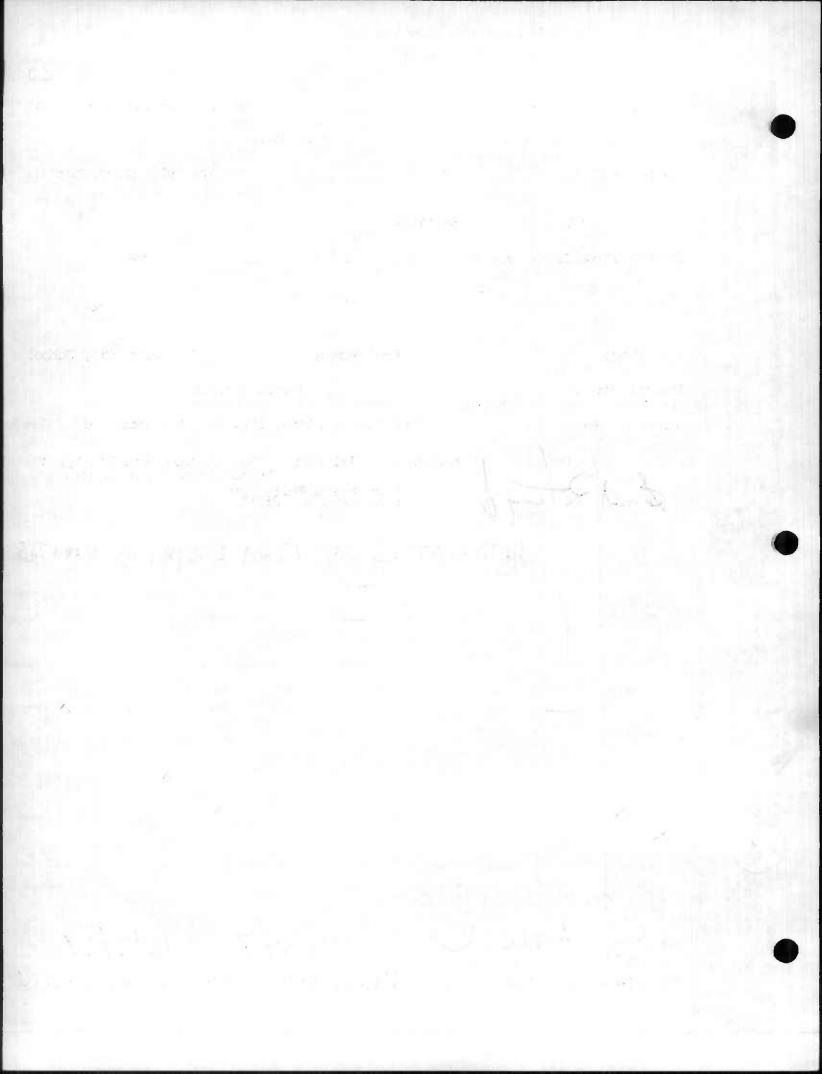
28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMSEL

861 PARK AVE 32. Registrar's Signature

28e. Placa of Injury - At home, farm, street, factory, office bullding, etc. (Specify)

31. Dete filed (Month, Day, Year) State OCT 0 8 1997 Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

					Certifica	ate of De	eath		Reg. No.	1	3032	
	The second	ecedent's Name (First, Middle, L	ast)					2. Date of D	eath Day	Year	3. Time of De	
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xaminer	160	acllity Name (If not institution, ge			10 11		City, Town, or L	ocation of Dea	th 4c. Count	of Death		
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No. 18	10a. State 10b. County 10c. City, Town or Location								10d. Inside City L			
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be nottled Director	10e.	Street and Number				Zip Code			10g Citizen of	. Citizen of What Country?		
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		Edgar	Clinton	Pai	rtlow		orothy		M. 1	Burke		
traumetic		Informant's Name/Relationship		19	b. Mailing Addra	ass (Street end	Number or Rui	rel Route Num	ber, City or Town	Stete, Zij	Code)	
other tr		anya Roberts -	Guardian		861 Park		and F	loor E	Baltimore	e,MD	21201	
		Method of Disposition I X Buriai 2 □ Cramation 3 [	☐Removal from State	20b. Place cemet	of Disposition (f ery, cremetory of	verne of or other piece)		Data	20c. Location	- City or To	own, State	
	4 Donation 5 Other (Specify) Woodlawn Cemetery Oct. 10, 1997 Iront									on, Ohio		
any injury or	21. 5	Signature of Funeral Service Lide	insee /		22. Nama	and Address of	Facility Le	eonard J.	Ruck, Inc.			
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	23a.	Part1. Enter the disease, or con shock, or heart failura. List only	nplications that caused	death. Do	not antar the m	ode of dying, su	ich as cardiac	or respiratory	arrest,	<u> </u>	Approximata	
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State of Maryland / Department of Health and Mental Hygiene 97

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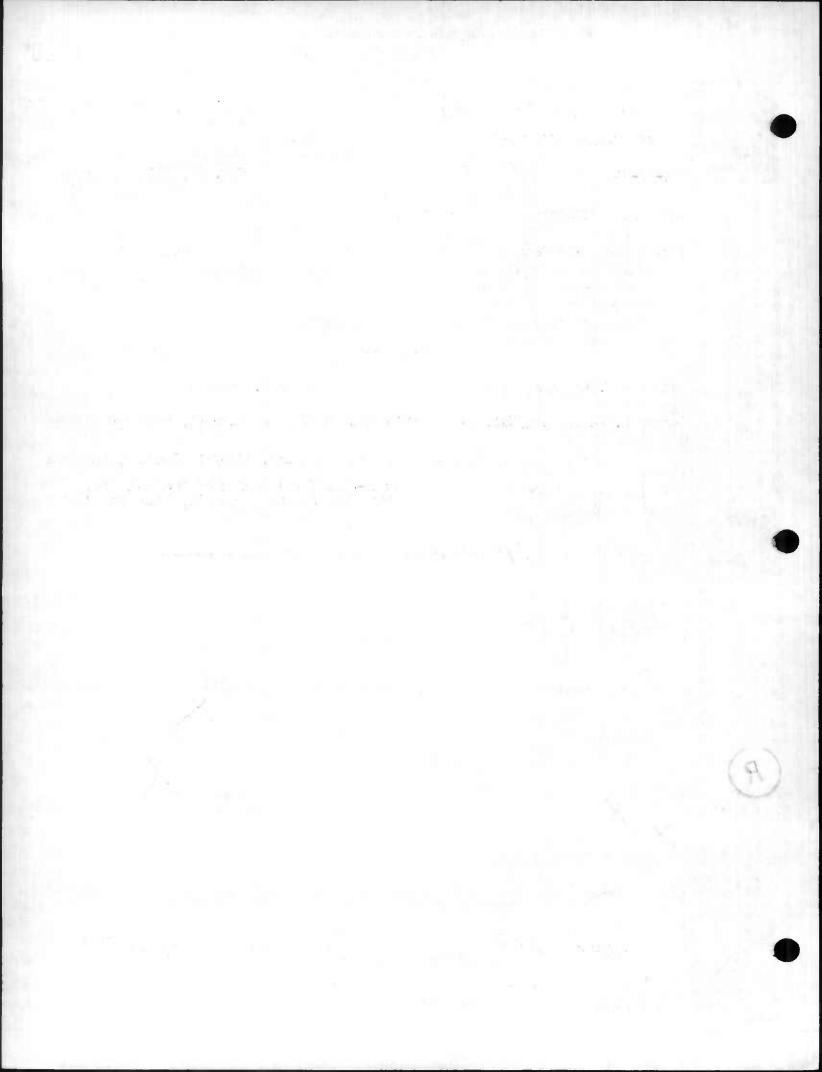
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Baltimore, semil Pages 1 er populariset et les populariset et liem ; montant et liem ; my injury or other 20ce.		4 Donetion 5 Other (Specification of State of Security	1					2020211	020,	1101) 10110				
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James Carlos Carlos Carlos Carlos

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 30528

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Exam		4a. Facility Name (If not institution, give	e street and number)				4b. City, Town, or	Location of Deeth	4c. County	of Deeth				
		7484 German Hi	ll Road				Dundalk		Bal	timor	e.e			
Funera	i	Social Security Number     6. S		s. lest birth		Inder 1 Year	If Under 24 Hrs Hours Min		h Year)	9. Birthpl	lece (Stete or	Foreign		
Directo		Usual Residence of Decedent	□M 2XF 68	City, Town	rs.		Hours Min	Dec. 2	yland					
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th with th	Funeral Director	10e. Street end Number 10f. Zip Code 21222							10g. Citizen of V United					
Dallimore, Maryland 21215-0020  Jenny Papes 1 and 2 should be filed within 72 hours after death with the Maryland Description of the filed Manial Hygiene.  Theorem of the file and Manial Hygiene.  Theorem of the file and filed the filed filed filed and any injury or other traumatic event, the Marical Evantine mant be notified at any one.	b	11. Marital Stetus  1 Never Married 2 Married  3 Widowed 4 Divorcad	12. Was Decedent Ever In Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:	U,S.		Decedent of I , specify Cub les 2 No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rec Bled	a - America ck, White, e Whi	etc.			
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any ir		21. Signeture of Funeral Service Licensee  Johnny J. Litts  22. Name and Address of Facility  Duda-Ruck Funeral Home of Dundalk, Inc.  7922 Wise Avenue Dundalk, Maryland 21222												
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Physician	٦	1. Decedent's Neme (First, Middle, Le	ist)			1775	C. VIII	2. Dete of De Month	eth Day	Year	3. Time of D	Death
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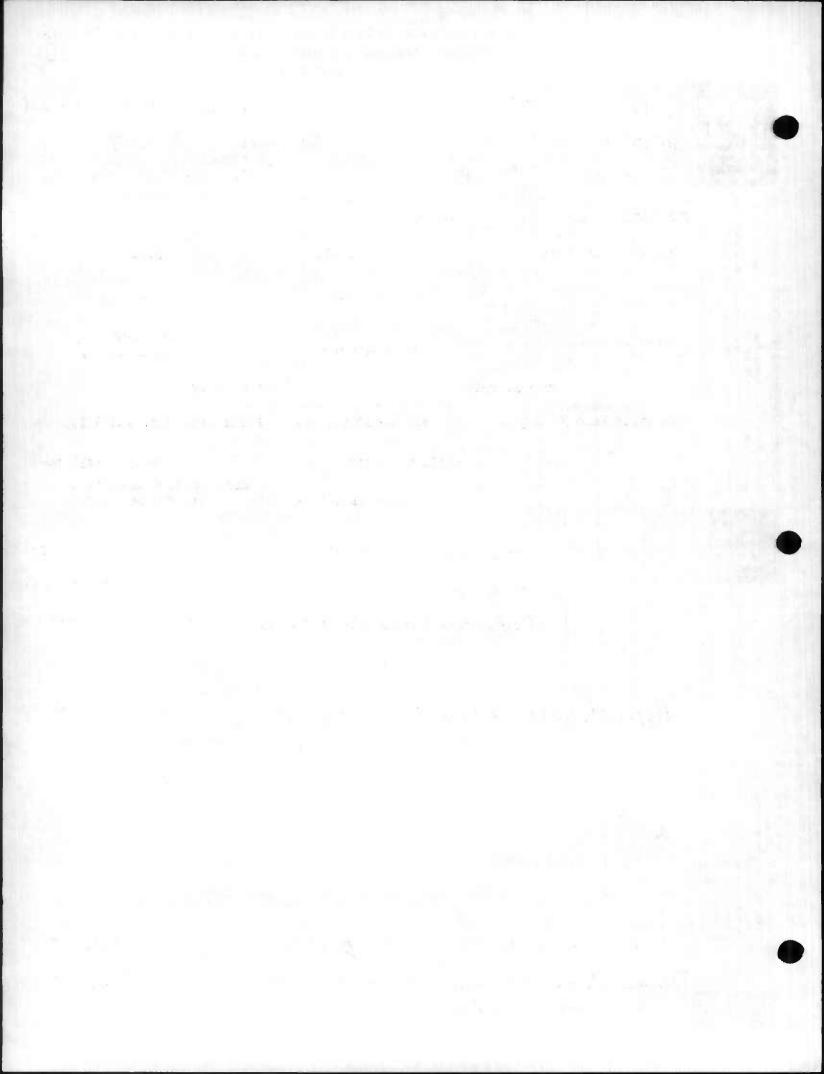
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State of Maryland / Department of Health and Mental Hygiene 9 7

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath **Physician** Month HELEN 4:11 AM September /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) 1 M 200 F Months Days Hours Vrs Director 44 July 22, Virginia 216 66 2559 the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Maryland N/A 11X Yas 2 No Director Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 839 Herndon Court 21225 U.S. Funerai 12. Was Dacedant Evar in U,S. Armed Forcas? 1 □ Yas 220 No If Yas, Giva Yaar or Datas: 11 Marital Status Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarlcan indian, Black, Whita, atc. 1X Nevar Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: by Specify: Black 3 Widowad 4 Divorced Completed 15. Dacedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "n Baltimore City Elamantary/Sacondary (0-12) Coilaga (1-4or 5+) Food Service 8th Public School 17. Fathar's Nama (First, Middle, Lest) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be John A. Reid Elva Henry 19a. Informant's Name/Raiationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Michelle Reid / daughter 839 Herndon Court Baltimore, Maryland 21225 20b. Piaca of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramovai from State 4 ☐ Donation 5 ☐ Othar (Specify) 10/6/97 Hilltop Service Corp. Towson, Maryland 21. Signature-of Funarai Sarvica Licansaa 22. Nama and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway ranciously Baltimore, Md. 21225 23a. Part1. Enter the disease, or on prications that caused the death. Do not anter the mode of dyling, such as cerdiac or respiratory arrast, shock, or heart failure. Listony one cause on each line. Approximate Intarval Batween Onsat and Death **Physician** /Medical immadiata Causa (Final Hypotension, disaasa or condition rasulting in daath) Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that Initiatad avants rasulting in daath) Last and C'ARCINOMA Metastatic to Liver P.O. Box 68760, ERVICAL ettending physician for use es the burie Physician/Medical the 80 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown Metabolic derangements 1 | Yes 2 | No Records, Be Completed by 9 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ate has b 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No certificate Vital director, 25. Was casa rafarred to medica! 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA ö 27. Mapnar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accidant 3 Sulcida 6 Could not be Piaca of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) or A efter 4 Homicida Hospital c To the Hospital within 24 hours e Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medical 29b. Signatura and titia of cartifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number Daniel Kolunn 30. Nama and addrass of parson who complated causa of death (Itam 23a), (Type, Print) Center State Registrar



WRC 97-5688-510 **ANGELYN** RILES

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

111 Penn Street, Baltimore, Maryland 21201

30531

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death OCT. 05, Day 1997 Year **Physician** ANGELYN L. RILES 1:00 PM. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SHOCK TRAUMA BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Dave Hours Min. (Month, Dey, Yea 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 20 F 216-42-8695 51 Yrs July 10 1946 South Carolina Director Usual Residence of Decedant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Baltimore Director n/a 10e. Street and Numbar 10f. Zip Code 10g. Citizan of What Country? 8 must be USA 21230 items 23a 1610 Patapsco Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Dacadent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 72 hours eftar 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or white 1 Yas 2X No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. City Parks event, me Recreation Leader 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Health and Mentel H Louise Riddle William Riles 20 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jerome Reider (Brother-in-law) 1060 Sixth Street, Glen Burnie, Md. 21060 Medi 20a. Method of Disposition

1 Buriel 2 Cremation 3 Ramoval from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Oct.10 Pages Dependent of Important of Indian or Glen Haven Memorial Park 1997 Glen Burnie, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home of South Balto. 130 E. Fort Ave., Baltimore, Md. 21230 23a. Part1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner certificate be axecutad and Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai the Due to (or as a consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, by Be Completed 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Tha law page 2 rificata ! Division of Vital 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1♥ Yes 2□ No Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Subject Foldows 2
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Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT

How Courred at the t 5 Pending investigation 1 Naturai 1 Yes 2 No Accident or Atten efter deal Director 28f. Locatio City or 3 Suicide 6 Could not be determined 4 Homicide 1610 Hospital To the Hospital within 24 hours e To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifias Medical 29b, Signal 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. OCT. 06, 1997 leted ceuse of death (Item 23a) (Type, Print)

State Registrar 31. Date filed

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32. Registrar's Signature

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(Month, Dey, Year)

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WRC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 97-5673-510 UNK. 97-219 State of Maryland / Department of Health and Mental Hygiene 30532 LUIS RAFAEL RODRIGUEZ Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Death Oction 04, Day 997 **Physician** 8:36 PM 19452 /Medicai 4a. Facility Name (If not institution, giva straet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE Security Number 44 If Under 1 Year if Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 1 M 2 F Days 023 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Townfor Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director itizen of What Country? 9 items 23a Funeral DE Was Decedent Ever In U,S Armad Forcas? Hispanic Origin? (Specify Yes or No-uban, Mexican, Puerto Rican, atc.) 14. Raca -11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Yes 2 □ No Baltimore, Maryland 21215-0020 6 Specify: Dominical Specify: CAN þ 3 Widowed 4 Divorced "natural", Completed 16a. Decadent's Usual Occupetion (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Busine s/Industry ring most of working filed within 7 Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) GENERA DOVER 102 17. Father's Name (First, Middle 2 should be fi Be Buen A ROCCIOUEZ 69 permit. Pages 1 and 2 Department of Health Important I light 27 in any following of other the Jullanburg 20b. Place of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee nni 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Bety Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, attending physician Physician/Medicai the Due to (or as a consequence of): o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy has page 2 certificate 2 No 1 Yes 2□ No ng Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1X Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: Alter injury 1 Natural 5 Pending 1 Yes investigation 1940 10.4.97 2 Accident 3 Suicide Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

4 Homicide

6 Could not be determined

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Pasan

OCT. 05, 1997

29a. Certifier (Check only one) 29b. Signature and titia of certific

31. Date filed (

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licensa number 29d. Date signed (Month, Day, Year)

O.C.M.E.

30. Nama and address of person who impleted cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar his Maridson-Randelle

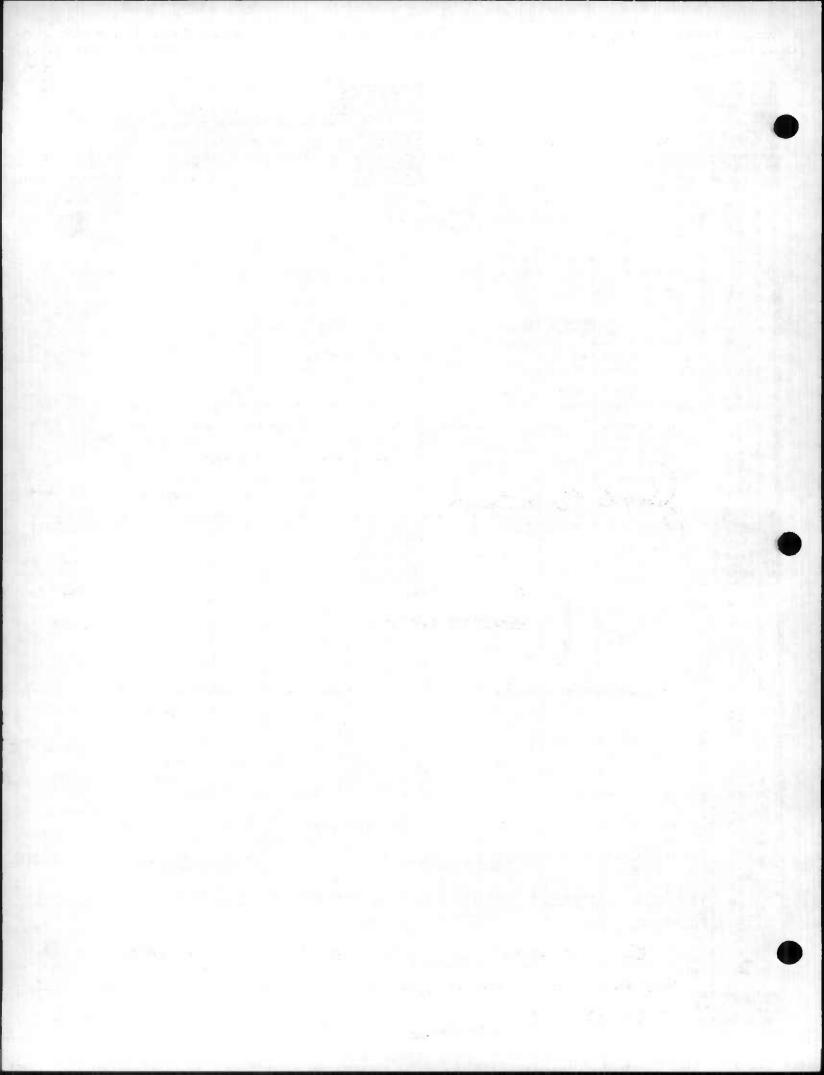
To the Hospital within 24 hours To the Fumeral

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State of Maryland / Department of Health and Mental Hygiene

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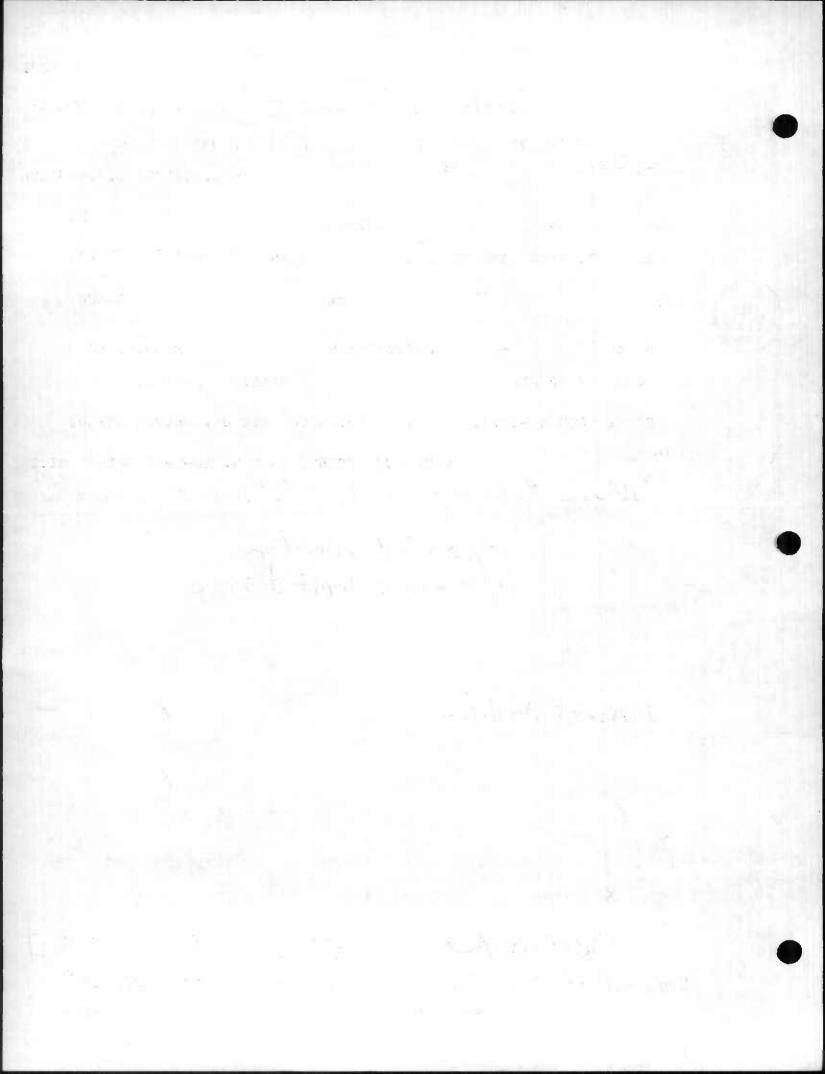
			Cer	tificate of	Death		Reg. No.	21	30333
cian	1. Decedent's Name (First, Middle, Li	ast)				2. Date of De	eath Day	Year	3. Time of Death
ical	MELVIN			ROGE	RS	SEPTE		1997	3:44 AM
ner	4a. Fecility Name (If not institution, gi	re street and number)			4b. City, Town, or				
198	THE JOHNS HOPK	INS HOSPITAL			BALTIMOR				
		1DIM OFF	yrs. last birthday)	if Under 1 Yea Months Days			th av. Year)	9. Birth	place (State or Foreign ntry)
	219-86-9184	3	Yrs.			June	2,1963	BAL	To, marylane
	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Loc	cation					10d. inside City Limits
7									1 ⊠ Yes 2 □ No
Director	MARYLAND N/	P	BACI	Timor					
	10e. Street and Number	7 1 10		10f. Zip Code	1001		10g. Citizen of		
Funeral		Ford A			1201			SK	
Š	11. Maritai Status	12. Wes Decedent Ever Armed Forces?	in 0,5.	Yes, specify Cu	Hispanic Origin? (S ben, Mexicen, Puer	to Rican, etc.)		ck, White,	can Indian, etc.
by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specif	y: , , ;	10 0 1=
ba	15. Decedent's E		16a Deced	ent's Usuai Occu	ination		16b. Kind of B		ACK
Siet	(Specify only highest gr	ade completed)	(Give I	kind of work done OO NOT use retire	e during most of wo ed)	rking	100. Kind of b	usiness/in	idustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		BORE			SeL=	7 6	mployed
	17. Father's Name (First, Middle, Last	)	- h'	1.00 1- 0		me (First, Middle			
To Be	HARRY RO	COPC			Annie	la a a ci a	o C.	, 1	
F	19a. informant's Name/Relationship		19h Mailin	n Address (Stree	et and Number or R		7.0	-	Code) ·
		** **							3 0000)
	Amie M.S. Char 20a. Method of Disposition	bers/moth	b. Place of Dispos	sition (Name of	LIL FORA	Date DA	20c. Location	· City or T	own State
	1 ☑ Buriai 2 ☐ Cremetion 3 ☐	Removal from State	Ob. Place of Dispos cemetery, crem	atory or other pl	ace)	10/2/2			
	4 Donation 5 Other (Speci					10/7/91	Dano	HLIT	, mar.
	21. Deprimere of Funeral Service Lice	nsee		Name and Addr			160.1	<b>T</b>	11 10.0
	years Re	Valtery	-	,				si v	10rth Ave.
	Part1. Enter the disease, or commock, or heart failure. List only	plications that ceused the one cause on each line.	deeth. Do not ente	or the mode of dy	ring, such as cerdia	c or respiretory a	rrest,		Approximete Intervei Between
	V							1	Onset and Death
	immediate Cause (Final diseese or condition	a SEPSIS							3 DAYS
	resulting in death)		to (or es a consequ	uence of):					J. DITTO
Examiner		ACUTE TYP	HLITIS					i	4 DAYS
cam	Sequentially list conditions,	Due	to (or as a consequ	uence of):					
Ē	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	RETROVIRA	L INFECT	ION				5	YEARS
edical	that initiated events resulting in death) Last	Due	o (or as e consequ	ience of):					
2		4							
lan/		d							
Physician/	Part ii. Other significant conditions of	ontributing to death but no	resulting in the un	derlying ceuse g	iven in Part I.	23b. Did	tobacco use co	ntributa t	o the cause of death?
		/				1 🗆	Yes 2 No	3 Pro	bably 4 Unknown
by		/							
Completed		./					an autopsy omed?	ev	ere autopsy findings valleble prior to
pie									ompletion of ceuse death?
5						10	Yes 2X No	1!	□Yes 2X No
Be (	25. Wes case referred to medical				28. Place of De	ath (Check only o	one)		
To	examiner? 1 ☐ Yes 2 ☑ No	Hospitai:	2 ER/Outpatient	3□ DOA O	ther	lome 5 ☐ Resi		er (Speci	(v)
	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. inje			how injury occur	- ' '	,,
atio	1 Naturai 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Yea	ir) injury		Yes 2 No				
III C	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury -		et, factory, office				ber or Run	al Route Number,
Certification:	4 LI HOHICIO	building, etc. (Sp.	necity)			City or To	wn, Stete)		
	29a. Certifier 1 Certifying Pt	yaiclan: To the best of my	knowledge, death	occurred at the t	ime, date end piace	and due to the	ceuse(s) end ma	anner as a	itated.
edicai	(Check only 2 Medical Exar	niner: On the basis of exar and manner stated.	ninetion and/or inve	estigation, in my	opinion, death occu	irred et the time,	date and place,	end due te	o the ceuse(s)
X	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)
	at o								
		SIDENT	(itom 92+) /F 5		ES-000		SEPTEMB	ER_28	8,1997
	30. Name and address of person who								
110	31. Date filed (Month, Day, Year)	TOWER 11.		HOPKIA	15 600 N	WOLFF	ST. BA	KTEM	ORF 71205
ite ar									
	OCT 0 8 1997	Julia Davidson	Brand. ac						
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State of Maryland / Department of Health and Mental Hygiene

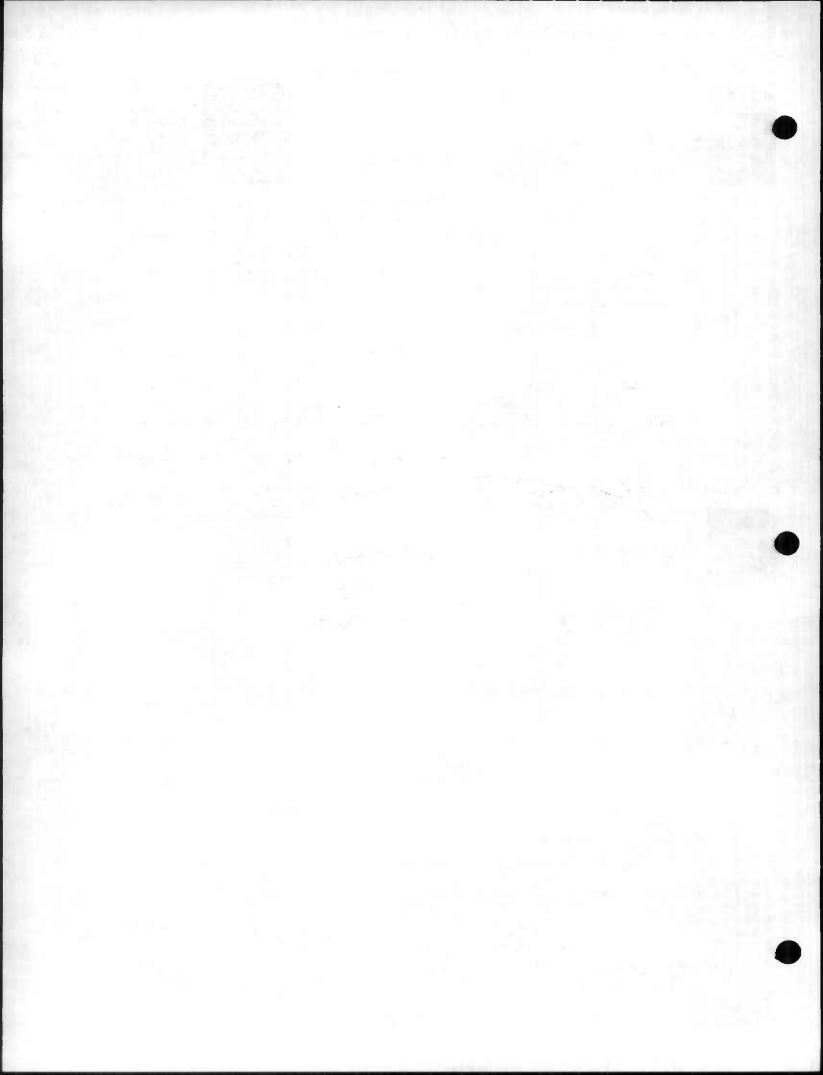
					Certificate	of Death		Reg. No.	9/3053		
Physici /Medio		Decedent's Name (First, Middle, La	Saray	凡元.	Stur	divant	2. Date of D Month OCT	Day OBER 5,	3. Time of Deat 1997 12:30		
Examir Funeral			erick ;	AVENUE ge (In yrs. last birti	Months	4b. City, Town, or State of the City of th	Timore s. 8. Date of B	4	9. Birmpiace (State or Fore		
Director		Usual Residence of Decedent									
f show led at	or	10a. State 10b. County		10c. City, Town				10d. inside City Lim 1∑1Xes 2□			
r 28a-1 sh Unotified	Director	MD na 10e. Street end Number	3		BALTIM 10f. Zip (			10g. Citizen of V			
23a or		4025 FREDER	ICK AVEN	302 NUE apt	IINT TOTAL COMP						
1	by Funeral	11. Marital Status  1 Never Married 2 Married  **X**Midowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2  H If Yes, Give Year or Dates:	Ever in U,S.		ent of Hispenic Origin? ( fy Cuban, Mexicen, Pue	Specify Yes or Norto Rican, etc.)	lo- 14. Rac Blac Specify	e - American Indian, ok, White, etc.		
題】	pote	15. Decedent's E (Specify only highest gr		16a.	Decedent's Usual	Occupation	arkina	16b. Kind of Bu	usiness/Industry		
11/	Comple	Elementary/Secondary (0-12)	College (1-4or		ife. DO NOT use	done during most of wo retired)	Jikiig	MIIDCI	NG HOME		
ther mt, th		17. Fether's Name (First, Middle, Las.	0	DI	GITITCI		ame (First Middl	e, Maiden Sumam	_		
c eve	o Be		PHRIE					BRIDGES			
umed	1	19a. informant's Name/Relationship	(Type, Print)	19b.	Mailing Address	Street and Number or F	Rural Route Num	ber, City or Town,	State, Zip Code)		
27 la		PATSY BOWN	MAN-Daug.				VENUE,	1	MORE, MD#		
sician edical miner	iner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		Due to for as a co		nfarction			Approximate Interval Between Onset and Death		
ettending physician end of for use as the bunal-transit	in/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last	c								
the ett	Physician	Pert II. Other significant conditions	contributing to death b	out not resulting in	the underlying car	use given in Pert I.	23b. Dic	23b. Did tobecco use contribute to the car			
900	by Phy	DiAbetes	Nelli	tis			1	3 Probably 4 Unkn			
has been signed I ge 2 should be det	Completed				150			s an autopsy ormed?	24b. Were autopsy finding available prior to completion of ceuse of death?		
certificate ha rector, page							1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No		
this certific ral director,	o Be	25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	0		Other:	ath (Check only		(D. 11.)		
r: After this e funeral di	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da			c. Injury at Work?  1 Yes 2 No	-	how injury occurr	er (Specify) ed		
I Director: After t ed in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of inj	ury - At home, fare c. (Specify)	m, street, factory,	office	28f. Location City or To	(Street and Numbown, State)	er or Rural Route Number,		
To the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one) Certifying Pt	nysician: To the best onliner: On the basis of and menner sta	r examination and	death occurred at for investigation, in	the time, date and place n my opinion, death occ	e, and due to the urred at the time	cause(s) and ma , date and place, s	nner as stated. and due to the cause(s)		
Toth	Me	29b. Signature end title of certifier	Arreyn	10	29c.	D2780	20	OCtob	Month, Day, Year) Pr 7, 199		
5		30. Name and address of person who CHRI STOPHER	D. KE	ARWEY	ype, Print) MO 7	DO WASHI	nks 701	BND -	BATMO		
Stat Registra	te ar	31. Date filed (Month, Day, Year)	Julia Jand	er's Signature	2				2/230		

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State of Maryland / Department of Health and Mental Hygiene 97 30535

					Cei	tificate c	of De	ath		Reg	. No.			
Physic	ian	1. Decedent's Name (First, Middle, Lt		zilvassı					2. Date (	of Death	Day	Year	3. Time of Death	
Physic /Medi		Piroska Eliz			Octo	ber	r 6, 1997		9:00 AM					
Exami	ner	4a. Facility Nama (If not institution, give street and number)  Citizens Nursing Home							or Location of De Grac					
Funeral Director			Sex 1 Age (In yrs. last birthday) If Under 1 Y Months D					Jnder 24 H ours N	lin. 8. Date (Mont	of Birth h, Dey, Y	<sup>(ear)</sup> 1923	Çquir	olace (Steta or Foralgr ntry) NGWLY	
show	ō	10a. State 10b. County  Maryland Harford	d	10c. City, To	wn or Lo		and					1	0d. Inside City Limits 1 ☐ Yes 2 X No	
or 28a-f	Director	Maryland Harford Edgewood  10e. Street and Number 10f. Zip Code								100	. Cifizen of \		ntry?	
eth wi		605 Mulberry La					21	040			U	I.S.A	•	
ges 1 and 2 should be filed within 72 hours efter deeth with the Maryland it of Health and Merkal Hygiene. If them 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Modical Examiner must be notified as	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Micropole	12. Was Decedan Armed Forces 1  Yas 2  If Yes, Give Year or Datas	? No	It Yes, specify Cube			ic Origin? axican, Pu ecify:	(Specify Yas of arto Rican, etc.)	or No- :.)	14. Rac Blac Specify	ean Indian, etc. ite		
	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or		(Give life. L	lent's Usual Oc kind of work do DO NOT use re Memaker	ne during tired)	g most of	working		Own Ho		dustry	
	To Be Co	17. Father's Name (First, Middle, Last Joseph Ablan	memuker	18.		Name (First, Mabeth	iddle, Me		ie)	wn)				
	1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or I  19b. Mailing Address (Street and Number or I  605 Mulberry Lane,												
		20a. Method of Disposition  1 A Burial 2 Cremation 3 Removal trom State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Neme of cemetery, crematory or other place)  Gardens of Faith Centers							Date 10/10/	10/10/97 Baltimore, Maryland				
Deserment Information any Injury Once.		21. Signature of Funeral Service Licenses  22. Name and Address of Facility  Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236												
Physician /Medical Examiner	niner	23a. Part Enter the disease, or com shock, or heart tailure. List only Immediate Cause (Final disease or condition resulting in death)	e	Due to (or as a	leu	HOALL	aying, su	ch as cerd	nac or respirati	ory arres	t,		Approximate Interval Between Onset and Death	
h certificate be executed ending physician end ruse as the bunal-transit	an/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):												
s that the death coned by the elternal of detached for us	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the			the cause of death?	
been signatures	Completed by									Was an performe		av	era autopsy findings ailable prior to mplation ot cause death?	
The lev ete hes page 2	Comp									1 ☐ Yas	20 No		Yes ZNO	
Physician: The I this certificate he ral director, page	Be	25. Was case reterred to medical examiner?	Hospital					Placa of I	Daath (Check o	on <i>ly</i> one)				
	on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpat		utpation Time of Injury	3 DOA	Other: 4 njury at Nork?	Nursin	g Home 5 D		ce 6 Oth		y)	
or Attendation of the or Attendation of the order or	ertification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homloide determined	e 28e. Place of In	njury - At home, f rtc. (Specify)	arm, stre		□ Yes ce	2 No		ion (Stre		er or Rura	Il Route Number,	
To the Hospital within 24 hours and To the Funeral completely filled	edical C	29a. Certifier (Check only one) 4 Cartifying Ph	nysician: To the best minar: On the basis of and manners	ot examination ai	e, death nd/or inv	occurred at the estigation, in m	time, de	ite and pla n, death or	ace, and due to	the cau	se(s) and ma	inner as si and due to	tated. the cause(s)	
With Total	Σ	29b. Signature and title of certifier	lefto	des			onse num	In of a	0		Date signe	(Month,	Day, Year)	
١		Ti KIONDO	completed cause of	MC 31	(Type, I	S. UM	od.	Me	1486	, n	Wa	207	8	
Sta Registr		31. Date tiled (Month, Day, Yeer)  OCT 0 8 1997	32 Regist	rar's Signature	andel	Ko.			/					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30536 Item: 23a per MD'G-753 11/17/97 dh Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Sept. **Physician** ALICE ELIZABETH STONER 30, 1997 1:15 PM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Caton Manor Nursing Center Baltimore N/A Hours Min. 8. Dete of Birth (Month, Day, Year Sept 5, 1 5. Sociei Security Number If Under 1 Year 9. Birthplece (State or Foreign 7. Age (In yrs. lest birthday) **Funeral** 1 M 2XX 245-26-4804 Yrs. North Carolina 76 Director Usuel Residence of Deceden 10e Stete 10b. Count 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Madical Example; must be notified at VXYes 2 □ No Maryland N/A Director Baltimore City 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1253 West Cross Street 21230 USA 12. Wes Decedent Ever In U,S. Armed Forcas?

1 ☐ Yes ②CNo
It Yes, Give
Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. permit. Pages I and 2 arould be filed within 72 hours after of Department of Hashiff and Mertel Hydiena.
Important: If Juni 77 is marked other than "naturel", or itsell important: If Juni 77 is marked other than "naturel", or itsell any injury, or other traumatic event, the Marical Examines 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Assembly Worker Eastern Products 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be UNKNOWN Lithia Elizabeth Nichols 19e. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Author Thompson (SON) 746 Old Riverside Rd., Baltimore, Maryland 21225 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Oct. 6 1 Burial 2 ☐ Cremetion 3 ☐ Removel trom State Cedar Hill Cemetery Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 1997 22. Neme end Address of Fecility
McCully-Polyniak Funeral Home of Brooklyn
237 E. Patapsco Ave., Baltimore, Md. 21225-1856 nature of Funeral Service Licensee Kevin E. Ecker Thur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if heart tailure. List only one cause on each line. Approximate tritervel Between Onset and Deeth **Physician** CIRRHOSIS OF LIVER /Medicai Immediete Cause (Finel ALCOHOLIC MONTHS diseese or condition resulting In deeth) Examiner Due to (or es e consequence of): Examiner **HEPATITIS** attending physician and for use as the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es a consequenca ot): Physician/Medical Due to (or es e consequence of): Pert ti. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown yd bengis 1 Yes 2 No P 24b. Were autopsy tindings aveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yes 2 No 1 Yes 2 WH Be 25. Wes case reterred to medical 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Vursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s)

29c. License number

21776

Box 68760, P.0. Division of Vital Records, Attending

with the Meryland

deeth

Baltimore, Maryland 21215-0020

Certification: Medical

or Attending effer death. by the To the Hospital c within 24 hours of To the Funeral D completely filled !

Registrar

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) SURYA MUNDRAMP 31. Dete tiled (Month, Day, Year) State

29e. Certifier

(Check only one)

29b. Signeture and Illie of certifier

OCT 0 81997

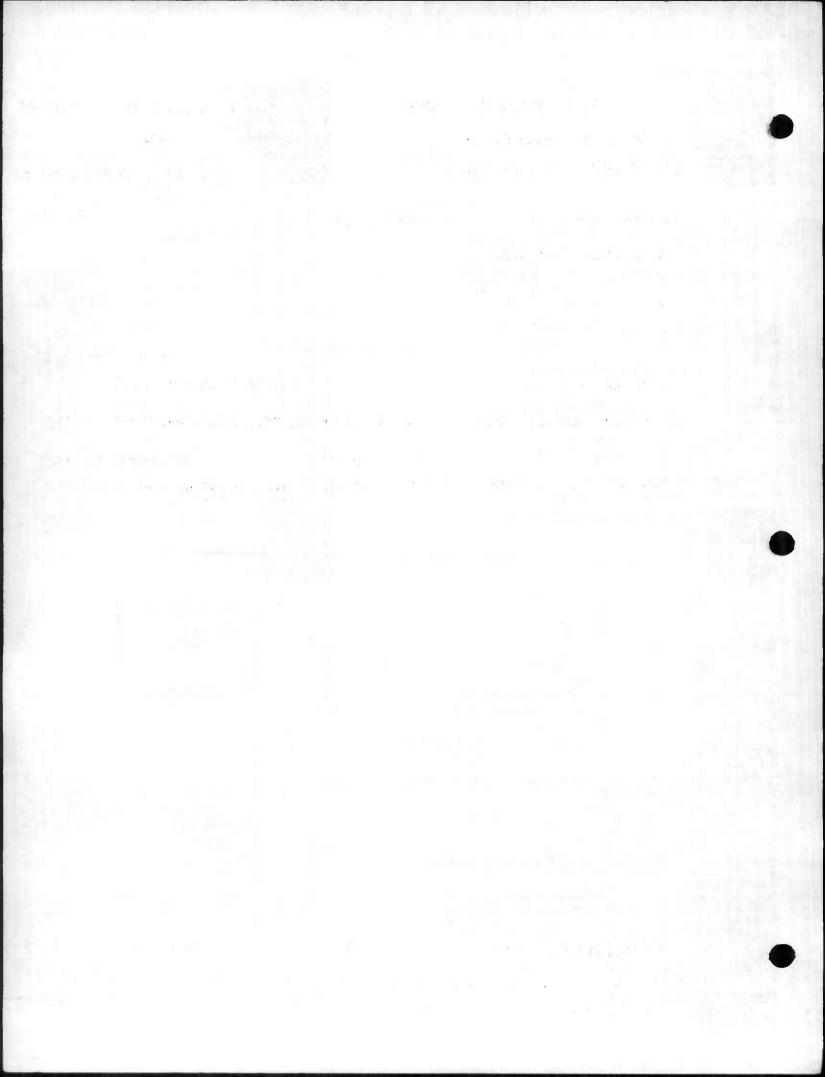


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29d. Dete signed (Month, Dey, Year)

OCTOBER 1

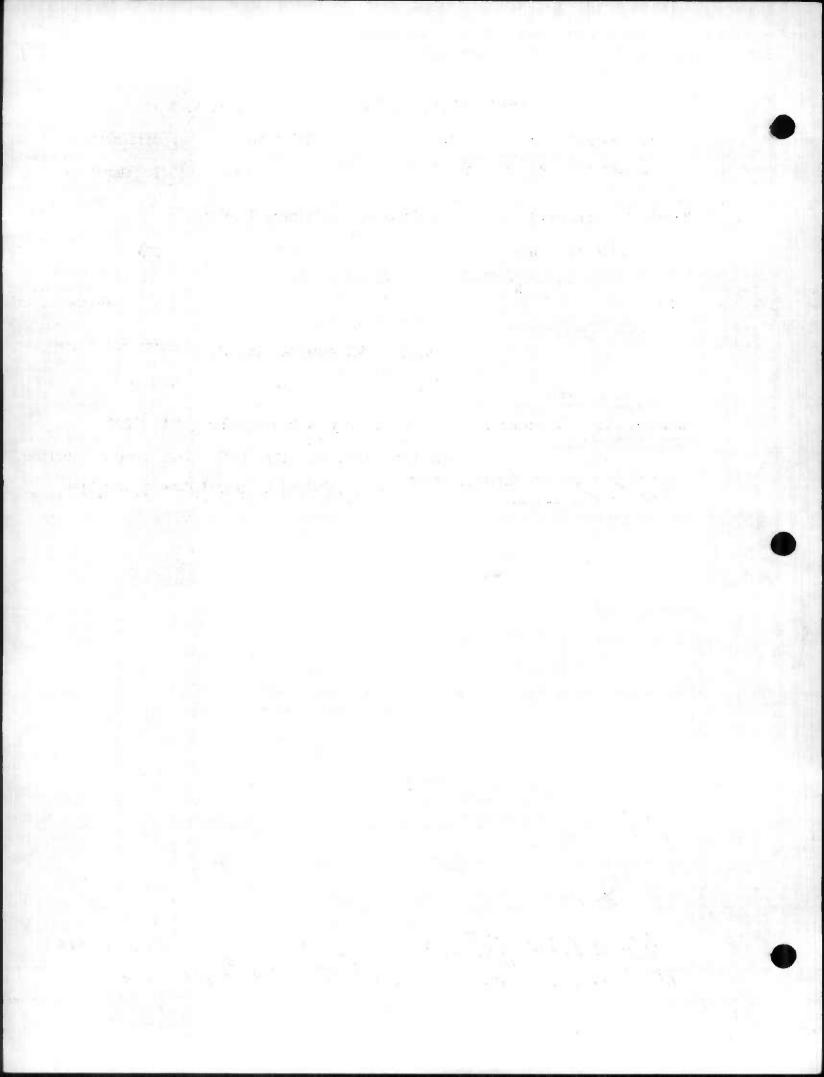
203 Erost PATAMSCO BACIMONE



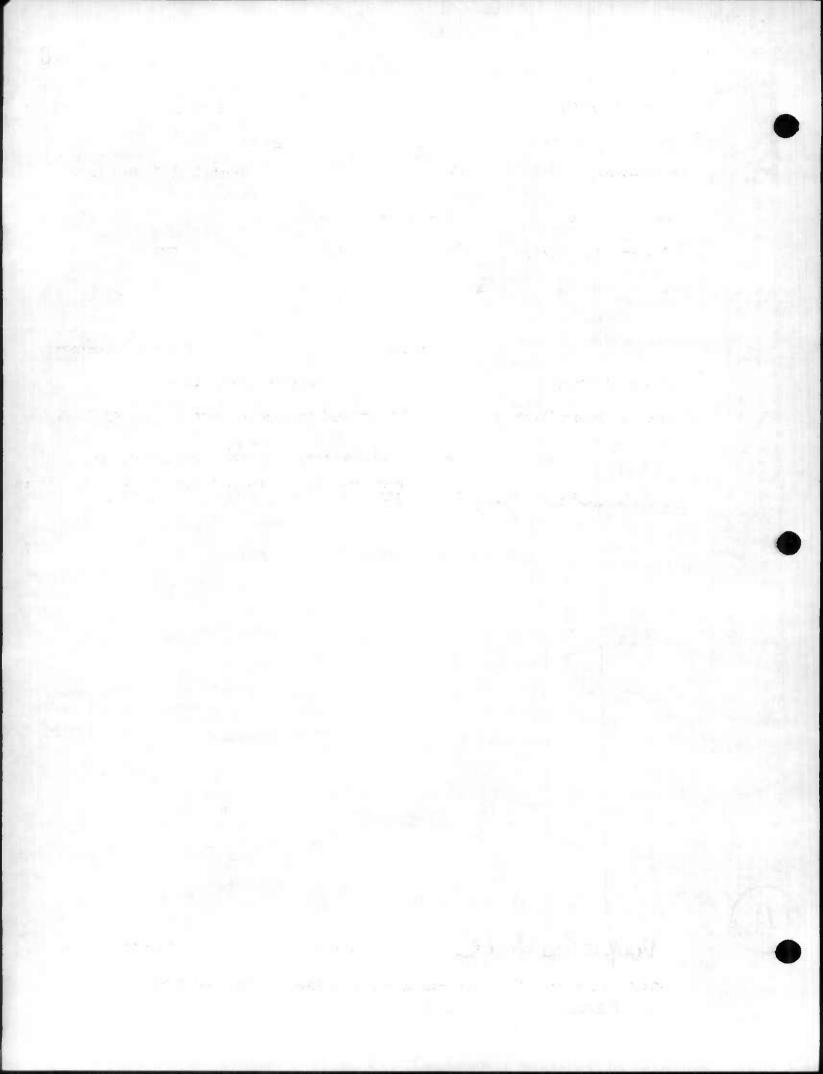
State of Maryland / Department of Health and Mental Hygiene

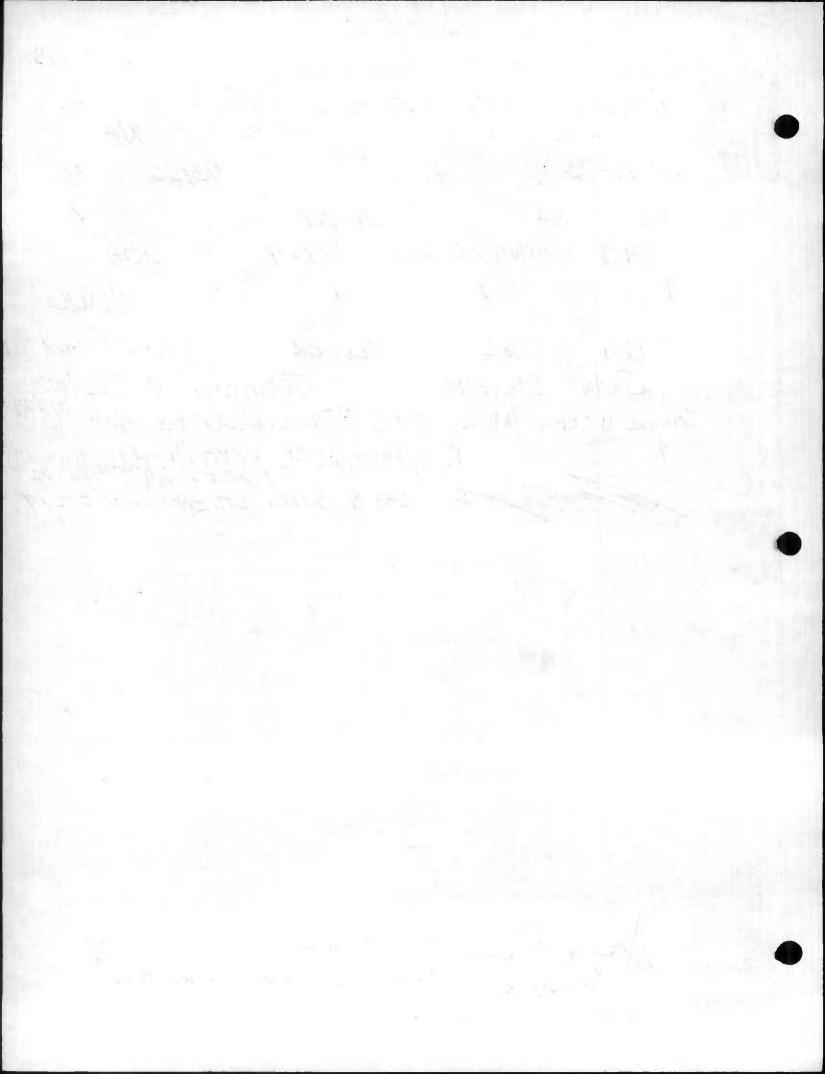
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					Ce	ertificate	e of	Death			Reg. No.		
Discover's		1. Decedent's Neme (First, Min								2. Dete of D	eeth	Yeer	3. Time of Death
Physic /Medi			THOMA	AS MI	LLIAM S	EIBEL				Oct.	4, 1997	7	3:55 AM
Exami		4a. Facility Name (If not Institu 2807 Flori			21227				wn, or Lo	cation of Dea		nty of Deeth	
Funeral Director		5. Social Security Number 219-28-4343	6. Sex 1 ⊠ M 2 □ F	7. Aga (In	yrs. lest birthde) Yrs.	) If Under Months	1 Yaar Days	if Under Hours		8. Date of Bi	irth		nplace (State or Foreign intry) Yland
		Usuel Residence of Decedent		00			-			Aug 4	, 1932	Mai	yranu
Menylend f show	tor	10a. Steta 10b. Cour Maryland Bal	timore	10	c. City, Town or L Balti		(Ba	ltimo	re H	ighlan	ds)		10d. Insida City Limits 1 ☐ Yas 2 No
with the la or 28a	Director	10e. Street and Number 2807 Florid	a Avenue			10f. Zlp	Code	21	.227		10g. Citizan		untry?
and 21215-0020  be filed within 72 hours effer deeth with the Meryland nat Hygiene.  d other than "natural", or Nems 23a or 28s-f show event, the Medical Exercises must be incidited at	by Funeral	11. Maritai Status  1 Never Merried 2 M  30X/Widowed 4 Divorce	Armed I	ecedant Evar Forces? s 2 No Give Detes:	in U,S. 13	Wes Deced If Yas, spec		lispanic Ori an, Mexicer Specify:		cify Yas or N Ricen, etc.)	0- 14. F E Spe	leck, White	icen Indian, , etc. White
21215-0020 d within 72 hours of gione. r then "neturel", or the Medical Exem	Completed	15. Deced (Specify only hig Elementery/Secondery (0-12	lent's Education hest grade complated  Collega	d) (1-4or 5+)	(Giv	edent's Usue e kind of wor DO NOT us	k done e retire	during mos d)			Contir		Bakery
be filed the Hygi d other event,	Be	9th 17. Fathar's Nama (First, Midd			Seibel	ed Ma	inte		er's Neme		e, Meiden Sum GloWa	ama)	Bunciy
should Ind Menial Indexes	2	Unkr 19a. Informant's Neme/Reletic	nown				(0)			/ Double Alicent			. 0.14.1
Mar are trau		Dolores Back (				Washi	ngt				., Md.	21227	
Baltimore, permit Pages 1 ar Dycartment of Nee Incorporate It New 3 any injury or other page.		1 ⊠ Burial 2 ☐ Crematio 4 ☐ Donetion 5 ☐ Other	(Specify)	m Steta	Glen Hav	en Mer	n. P	k. 1	0/6/	1997	Glen E	Burnie	e, Maryland
Bail December any in		21. Signature of Funerel Servi	ce Licensee Kev	/in E.	Ecker	McCul 237 E	ly-P Pa	olyni tapso	iak F	uneral e., Ba	Home o	of Bro	ooklyn 21225-1856
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/Medical		Immediata Ceuse (Finel diseese or condition	4	lung	Conce	3						1	144.
Examiner	Jer	resulting in deeth)	Θ	Que	to (or es e conse	equence of):						i	
X 68760, certificate be executed ding physician and ise es the buriel-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest	c		to (or es e conse								
death death e atten	Physician	Pert II. Other significant cond	Itlons contributing to	death but no	t resulting in the	underlying ce	euse giv	en in Pert I	l.		_		to the cause of death?
S, P. es that the igned by be detact	by Pt									1)%	Yes 2 N	3 Pr	obably 4 Unknow
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r Vital	Be	25. Wes cesa referred to medi exeminer?	-				011		of Deeth	(Check only	one)		
	2	1 ☐ Yes 200 No 27. Menner of Deeth		Inpatient e of Injury	2 ER/Outpetie			4LI NU			how injury oc		ify)
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	Certification:	3 ☐ Sulcide 6 ☐ Cou 4 ☐ Homicide dete	mined 200. Pier	ce of Injury - Iding, etc. (S)	At home, ferm, s pecify)	treet, fectory	, office		2	28f. Location City or To	(Street and Nu own, Stete)	mber or Ru	ral Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (	29e. Certifier (Check only one)	ying Physician: To the al Examiner On the end me	ne best of my besis of exe	knowledge, dee minetion and/or in	th occurred envastigation,	t the tir in my o	ne, date en pinlon, dee	d place, a	nd due to the	cause(s) end , dete and plac	menner as e, and due	stated. to the cause(s)
To the within 2 To the comple	Me	29b. Signature and little of certi	fier //	1	,	29c	Licens	e number			29d. Date sig		
6		My Co	Walux	sof c	10		02	LY39	56		Octor	Pres 4	1,1997
IVA		10/10 C 11/12/15	on who completed	use of deeth	(Item 23a) (Type	Print) S;	+ A	lyncs	1 ten	et ca	1/2/1	-29	4, 1997
Sta Registr		31. Dete filed (Month Day, Yes	197 Ju	Registrar's S	Signature Con-Panda	عاد							



OWNERS OF TAXABLE PARTY.		art I 27 per MEO G-752 1. Decedent's Name (First, Middle, Las		061	tificate of	Douti	2. Date of Deat		3. Time of Death
ysici Vedic	al	ROBERT W. STEIN  4e. Facility Name (If not institution, give	street and number)			4b. City, Town, or L	Month SEPTE	Day /BER 30 4c. County	
amin	ier	2831 ST. PAUL ST				BALTIMO			J/A
eral ctor		5. Social Security Number 6. Sr 085-44-4684		yrs. lest birthdey) Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, March 7	Yeer)	9. Birthplace (State or Foreign Country) New York
16		Usual Residence of Decadent  10a. Slete 10b. County	10c.	City, Town or Loc	cation				10d. Inside City Limits
tilled	ctor	Md. n/a		Baltimor	e				Yes 2□No
Den	Director	10e. Street and Number 2831 St. Paul St	voot		10f. Zip Code 21218		10	0g. Citizen of V USA	What Country?
event, the Medical Examiner must be notified at	Funeral	11. Marilei Slatus	12. Was Decedent Ever in Armed Forces?		Ves Decedent of H	Hispanic Origin? (Sp en, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Rac	a - American Indian, ck, White, etc.
Examir	by	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:	1	☐ Yes 21XNo	Specify:		Specify	white
9000	letec	15. Decedent's Ed (Specify only highest gree	ucation de completed)	(Give I	ent's Usual Occup kind of work done OO NOT use retire	during most of work	king	16b. Kind of Bu	usiness/Industry
IDs M	Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	Clerk		u)		Federal	L Goverment
tic event,	To Be C	17. Father's Name (First, Middle, Lest) Stanley J. Stein				18. Mother's Nam Beatrice			10)
e traumatic		19e. informant's Name/Relationship (7) Peter J. Stein (				end Number or Rui			Stete, Zip Code) ersey 08502
ry or other tr		20a. Method of Disposition  1 Burial 2 X Cremation 3 D  4 Donation 5 Other (Specify	Removal from State	b. Plece of Dispos cemetery, crem Green Mou	atory or other ple	ce) terv	Oct.2	20c. Location - altimor	City or Town, State
any in dry		21. Signature of Funeral Service Licens		/ 22 Mc	Name and Addre		uneral H	ome of	South Baltimor
ical iner		Immediate Ceuse (Final disease or condition resulting in death)	HYPERTENSIVE	ÄTHEROSCLE	ROTIC CAR				
-transit	kamine	Sequentially list conditions,	b. —	o (or as e consequence o (or as a consequence	uence of):	DIOVASCULAR	DISEASE		1 5,2
use es the buriel-transit	n/Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to	o (or as e conseq	uence of): uenca of):	DIOVASCULAR	DISEASE		
or use	edicai	Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to	o (or as a consequ o (or as a consequ o (or as a consequ	uence of): uenca of):			bacco use cor	ntribute to the cause of death?
or use	Physician/Medicai	Cause (Disease or Injury that infliated events resulting in death) Last	b. Due to	o (or as a consequ o (or as a consequ o (or as a consequ	uence of): uenca of):		23b. Dld to	bacco use cor	ntribute to the cause of death?  3 Probably 4 Unknown
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director, page 2 should be detached for use e	To Be Completed by Physician/Medical	25. Was case referred to medical examiner?  XIX Yes 2 No  27. Menner of Death XIX Natural 1 Nestigation 3 Suicide 1 Homicide	b. Due to c. Due to d	o (or as a consequence of or as a consequence	uence of):  uenca	zen In Part I.  26. Place of Deal ner: 4□ Nursing Ho ry et rk? Yes 2□ No  me, dete end plece, pplnion, death occur	23b. Dld to  1 Ye  24a. Was ar perform  XXX Ye  th (Check only one)  5 X Reside  28d. Describe ho  28f. Location (Str. City or Town)  end due to the cared et the time, da	n autopsy ned?  s 2 No  e)  nnce 8 Other  we injury occurr  reet end Numb  c, Stete)  uuse(s) end ma ate and place, to	3 Probably 4 Unknown  24b. Were autopsy findings aveilable prior to completion of cause of deeth?  XXYes 2 No  er (Specify)  red  per or Rurel Route Number,
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death Month **Physician** 5 1997 5:45 am October Marie Schwesinger /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1□M 2X F Months Days Yrs. 215-05-5783 Director 83 7-6-1914 Maryland Usuai Rasidance of Decedant 10c. City, Town or Location 10a. Stata 10b. County 10d. Insida City Limits the Marylar ahow rms 23a or 28a-f s r.mast be notified 1 ☐ Yas X No Director Maryland Baltimore Glen Arm 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? "natural", or Items 23s or 11630 Glen Arm Road 21057 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 No 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Biack, Whita, atc. 72 hours after 1 ☐ Nevar Married 2 ☐ Married 21215-0020 1 ☐ Yas 2 ☐ No Specify: White À 3CXWidowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 8 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be John Walters Mary Svec 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Maliing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) payorit. Pages 1 and Department of Health a Cimportant: If Item 27 is any injury or other tringonce. Anne Townsend (Daughter) 13809 Manor Glen Road, Baldwin, Maryland 21013 Baltimoře, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlai 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. 10-9-97 Baltimore, Maryland 22. Nama and Addrass of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funarai Sarvice Licensee 1050 York Road, Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batw Onsat and Death Physician Immediate Cause (Final disaasa or condition rasulting In death) /Medical Recurring Strokes **Examiner** Dua to (or as a consequence of): Examiner attending physician and for use as the burial-transit Sequantially list conditions, if any, laeding to immadiate causa. Entar Undarlying Causa (Diseasa or Injury Dua to (or as a consequence of): 68760, certificate be Physician/Medical that initiated events rasulting in death) Last Dua to (or as a consequence of): Box signed by the a P.O. Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, g 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen s Sac 1 Yas 2 No certificate 1 ☐ Yes 2 ☐ No of Vital 25. Was cesa rafarred to medice axaminar? Be 26. Place of Death (Check only ona) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To his 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Aftert Division or Attending 5 Panding invastigation death. 1 ☐ Yas 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) efter 4 Homicida o the Hospital or within 24 hour To the Fire 29a. Certifier fCXCertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and dua to the ceusa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. Medical (Check only one) 29b. Signatura and litla of cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

State Registrar

OCT () 91007

31. Data filed (Month, Day, Year)

Penelope Edwards, M.D.

32. Registrar's Signatura

2300 Dulaney Valley Rd

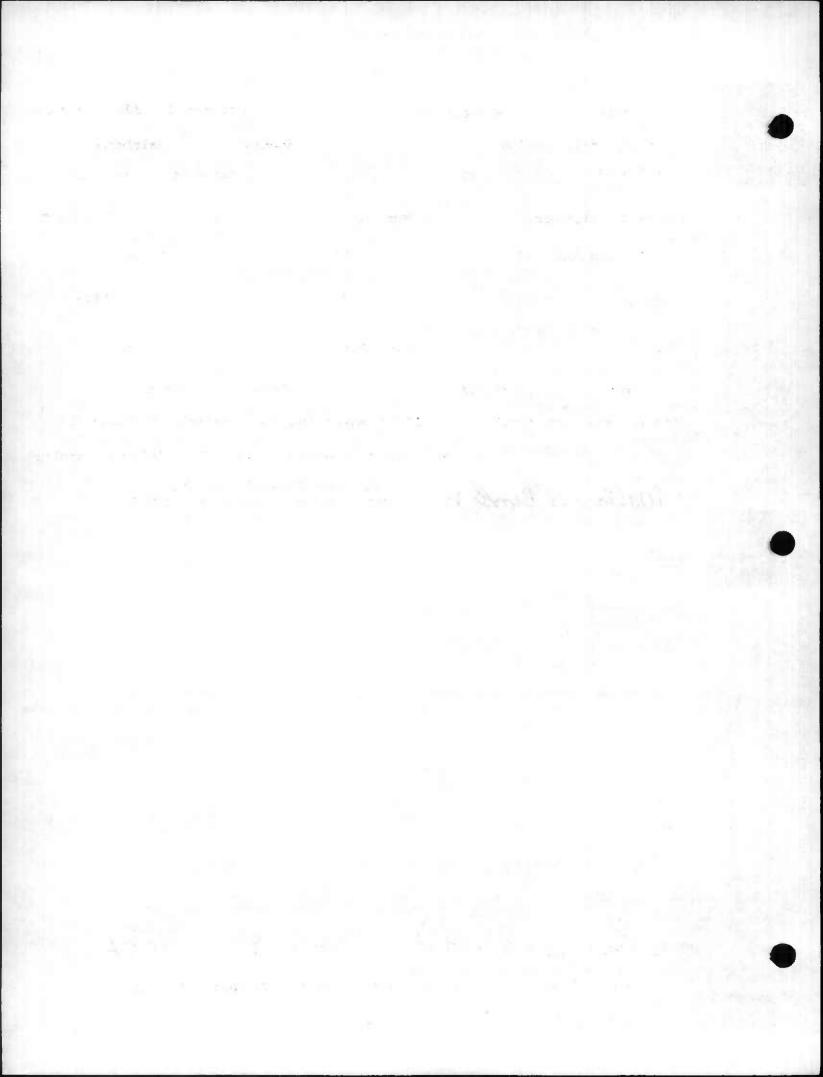
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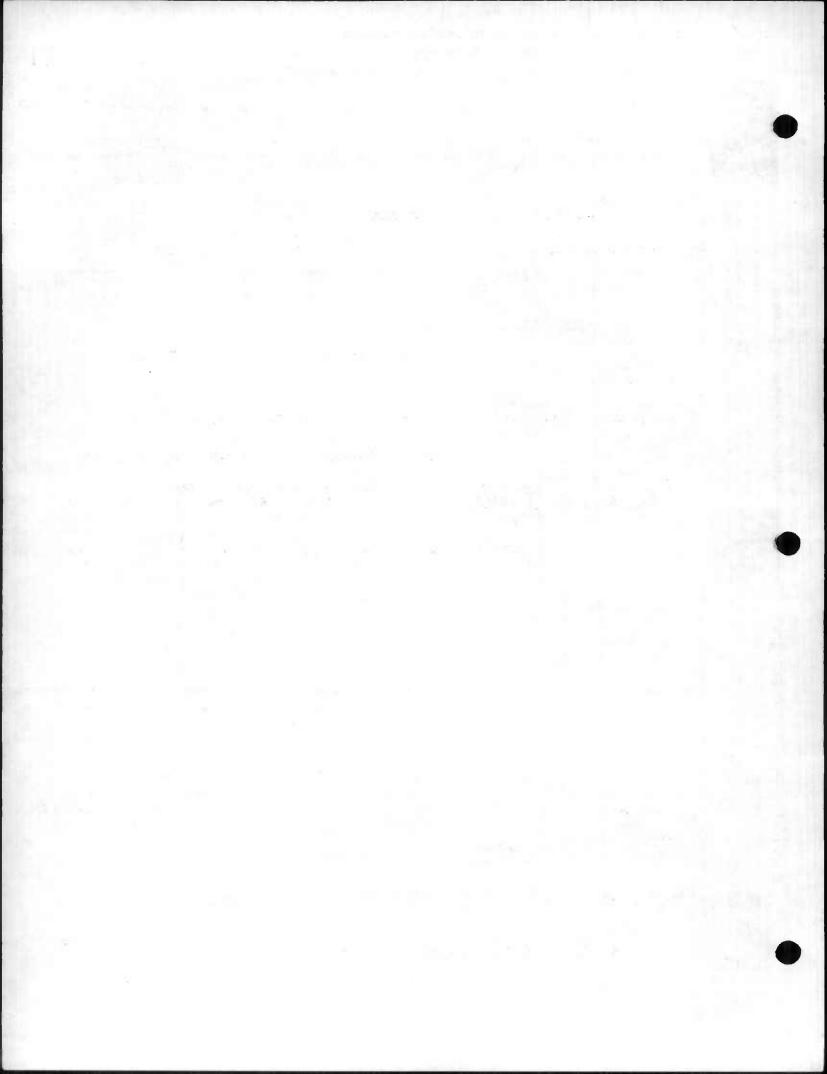
Marie

NAME



State of Maryland / Department of Health and Mental Hygiene 97

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Physician	,	1. Decedent's Neme (First,	Middle, La:	st)						2. Dete of D Month	D	ey	reer	3. Time Death
/Medical Examiner	ı į	Olive 4e. Fecility Name (If not Ins	titution, giv	a street and nur	n <i>ber</i> )		Sm:	ith	4b. City, Town, o	or Location of Dea		c. County of		11:00%
-xamme		The Gilcre							Towson	1			imor	re
uneral rector		5. Social Security Number 579–16–0937		ax □M 2∏ F	7. Aga (In yrs	last birtl	Monti	der 1 Yea hs Deys			rth a <i>y, Year</i> -20	7)	9. Birthple Count	eca (Stata or Foreign (TV) MI)
ž ==	-	Usuel Residence of Deced 10a. State 10b. 0			10c, C	ty, Town	or Location						10	Od. Inaide City Limits
ar elements	5	MD Ba	1timo	re		C∈	edonia							1 ☐ Yes 2∏ No
ritems 23a or 28a-f e siner must be notified Funeral Director	a Cin	10e. Street end Number 4800 Sip	ple A	ve.			10f.	Zip Code	21206		-	itizan of Wh	et Count	try?
by by	2	11. Maritel Stetus  1 Navar Married 25  3 Widowed 4 Div		12. Was Dece Armed For 1  Yes If Yes, Giv Year or Da	rces? 2 No	I,S.		cedant of specify Cul		(Specify Yas or N arto Rican, atc.)	0-	14. Reca- Black, Specify:	White, e	etc.
natur Polical	בוני		cedent's Ed highest gra	lucation de completed)		16e. I	Decedent's U Give kind of	sual Occu work done	petion during most of v	vorking	16b. l	Kind of Bust	ness/Ind	ustry
	1	Elementery/Secondary (	)-12)	College (1	-4or 5+)		Book F					) 10 d to 1 d		
or other traumatic event, the M	3	17. Father's Name (First, N Claude DeM	iddla, Last)				DOOK 1	ieepe	18. Mother's N	lame (First, Middle (unk.)		rinti n Sumeme)		
r traumat		19e. Informent's Name/Re George Smit								Rurel Route Numi 1timore		or Town, St		Code)
any injury or other transfer.		20e. Method of Disposition 1 Mg Burial 2 ☐ Crem 4 ☐ Donetion 5 ☐ Ot					Disposition (// cremetory of COOD CE			Dete 10-7-97		ocation - C		
any injury		21. Signeture of Puneral S	ervice Ligen	100	2.		Cv	rach/	ess of Fecility Rosedale	Funeral Ave. Bal	Hom	ie No M	70 0	1007
	1	23e. Part1. Enter the disas shock, or heart feilure	sa, or comp	olications that co	aused the dea	th. Do no	ot enter the m	node of dy	ing, such es card	iac or respiretory	errest,	ore, M		1237 Approximete Intervel Between
iclan dical niner		Immediate Ceuse (Final diseese or condition resulting in deeth)			19-24	Ag-		str		Lung		sense	1	Onset and Deeth
ner ner					0 0 000	JI 65 a CI	onsequenca	01).					1	
s the bunel-transit		Sequentially list conditions if eny, leeding to immediet cause. Enter Underlying Cause (Disease or Injury		В. ————————————————————————————————————	Due to (	or es e co	onsequenca o	of):						
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funer form		2 Accidant	anding nvestigation	No	f Injury h, Dey Yeer) 18	28b, Ti	me of jury M	28c. inje We 1	iryet ork? ]Yes 2 ☐ No	28d. Describe	how inju	ury occurred	i	
ed in by the ed in by the Certifical		3 Suicida 6 0 4 Homicide	Could not be letermined	286. Pieca	of Injury - At h ig, etc. (Speci		m, straet, fac	tory, office		28f. Location City or To	(Street e wn, Stal	and Number te)	or Aurai	Routa Number,
To the Funeral Dir completely filled in Medical Cerl		29a. Certifier 12 Ce (Check only 2 ☐ Me	rtifying Phy dical Exam	valcian: To the ilner: On the ba and menn	sis of examina	wledge, ition end	deeth occurr or investigeti	ed et the t ion, in my	ime, dete end ple opinion, deeth oc	ca, end due to the curred et the time	cause(s	s) end menr nd pleca, en	ner es ste d due to	eled. the cause(s)
To the		29b. Signeture and fitte of o	artifier	10				_	se number			ete eigned (		
10		C/1- Has	hony	Kile	No.	m			205			o ber		
1		30. Name end eddress of p	erson who	completed cause	deeth (Ite	n 23e) (1	ype, Print)	les	St. B	alto.	mJ	21.	209	<
State	1	31. Dete filed (Month, Day,		32. R	ogistrar's Sign		799							



State of Maryland / Department of Health and Mental Hygiene 30542 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day **Physician** Frances Τ. Severa 1997 0730 AM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2☑F 219-10-0003 72 Yrs. Director 4-26-25 MD Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at MD Baltimore Rosedale Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 'natural', or items 23a or 8227 Dorset Ave. 21237 USA Funerai 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Never Married 3 Married 1 ☐ Yes Z∑ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2/☐ No by Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) 12 0 Sales Person Retail marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be and Mental Gustav Sterba Josephine Lane 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Important: If Item 27 is a Frank Severa Sr./ husband 8227 Dorset Ave. Rosedale, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State b 1 D(Buriel 2 Cremetion 3 Removel from State Most Holy Redeemer 10-8-97 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name and Address of Fecility Cvach/Rosedale Funeral Home 23a. Part1. Enter the disease, or complications that daused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, ahock, or heart feilure. List only one ceuse on each line. 1211 Chesaco Ave. Rosedale, MD 21237 Approximete interval Betw Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MALIGNANT ARRHYTHMIA Examiner Due to (or as e consequence of) Examiner ACUTE MYOCARDIAL INFARCTION physician and s the burial-transit that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): CORONARY ARTERY DISEASE Physician/Medicai Due to (or es a consequence of) use as for use as Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? detaci egned by 1 ☐ Yes 2 ☐ No 3 Probably William RECENT CORONARY ARTERY BYPASS SURGERY by 8 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Be Completed CONGESTIVE HEART FAILURE BW 24 No DIABETES MELLITUS 1 ☐ Yes X No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Neturel 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Attending 5 Pending investigation 1 Yes 2 No 2 Accident Director: d in by the 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) or A after 4 Homicide To the Heapital or within 24 hours at To the Funeral Di completely filled in Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) end menner es stated.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piace, end due to the ceuse(a) and menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 37254 dva 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) BOON P. LIM, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Dey, Year)

OCT 0 8 1997

22 Registrar's Signeture

Baitimore, Maryland 21215-0020

P.O. Box 68760,

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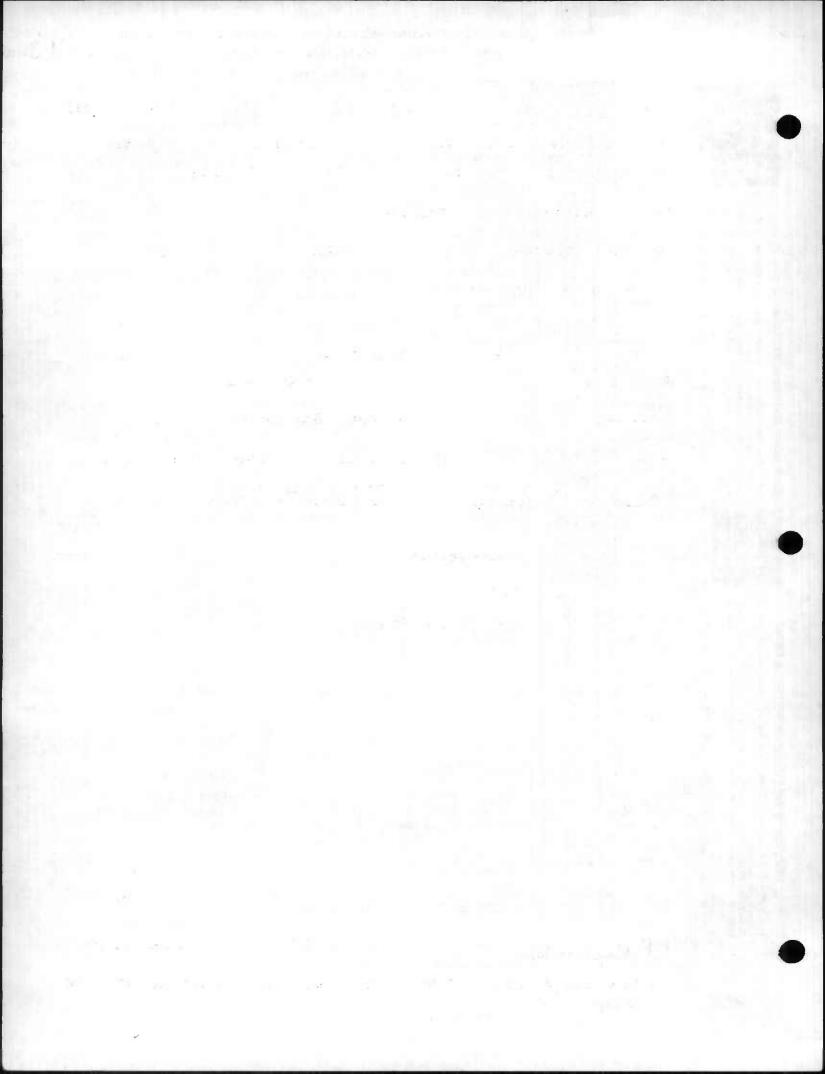
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Dhuniai		1. Decedent's Neme (First, Middle,	Last)			-			2. Data of Dec			Yaar 3	. Tima of Death
Physici /Medic		Edward	J.		SOU	L	Sr		October		1997		4:17 am
Examin		4a. Facility Name (If not institution,	give street end numbar)				4	lb. City, Town, or I	Location of Death	4c.	County o	f Death	
		Franklin Squa						Rosedal				ltimor	e
Funerai Director		214-12-4994	5. Sax 7. Ag	84 (In yrs. la	st birthday) Yrs.	If Under Months	Deys	If Undar 24 Hrs. Hours Min.	8. Data of Birt (Month, Da) 11-1-	h v, <i>Year)</i> 12		9. Birthplace Country)	(State or Foreign
show	J.	Usual Rasidance of Dacedant  10a. Stata 10b. County  MI) Balti	more		Town or Lo								Insida City Limits
or 28a-f	Funeral Director	10e. Street and Number				10f. Zip				10g. Citi	izen of Wi	hat Country?	
23a	rai	5919 Shadyspr	ing Ave.				212	37			USA		
ral', or items 23a or 28a-f show Examiner mant be nutified at	by	11. Marital Status  1 □ Naver Merried 2 ☑ Marrie  3 □ Widowed 4 □ Divorced	12. Was Dacedant Armed Forces? d 1 ☑ Yas 2 ☐ If Yes, Giva Yaar or Dates:			Was Dace if Yes, spe 1 □ Yas	cify Cube	ispanic Origin? (S in, Mexican, Puart Specify:	pecify Yas or No- o Rican, atc.)			- Amarican II , Whita, atc. Whit	
"natural", edical Exp	Completed	15. Decedant's (Specify only highest	Education grade complated)		16a. Dece	kind of wo	rk dona	during most of wor	king	16b. K	Ind of Bus	inass/Industr	у
ther then nt, the Me	idu	Elementary/Secondary (0-12)	Collega (1-4or	5+)		DO NOT u							
int,		17. Fethar's Name (First, Middla, Li	est)		Pa	per F	lange	-	ne (First, Middle,			nterio.	r
70 66	To Be	James Soul							vetz			,	
tem 27 is marked or other traumatic ave	-	19a. Informent's Name/Ralationshi Edward Soul Jr.						and Number or Ru Ave. Bal			or Town, S		ia)
= -		20a. Mathod of Disposition  1 ☐ Burial 2 ☐ Crametion 3 4 ☐ Donation 5 ☐ Other (Spe		cen	ce of Disponatary, crar	matory or o	othar plac		Data 0-6-97			City or Town,	Stata
Important: If any Injury or once.		21. Signatura of Funaral Sarvica L	X K 00		22	Cvac	h/Ro	ss of Fecility Sedale F	uneral I	lome			
		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause	tha daath.	Do not ant			esaco Ave g, such es cardiac			М	21237 Apr	proximata arval Between
sician ledical		Immediata Causa (Final disaasa or condition	Severe		osis							On	Hours
aminer		rasulting In death)	а.	Dua to (or a		quance of):							nould
Sit	line		Anemia	1									
end el-tran	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Dua to (or a	is a consec	(uence of):							
pni		cause. Entar Undarlying Causa (Disease or injury that initiated evants	c. Poor M				9						
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d for u	iciar	Part II Other significant condition	sontributing to death b	it not requite	ing to the cu	adadda a		on in Boat I	225 DIde			ulibrate to the	March of death?
80	y Physician	Part II. Other significent conditions	s contributing to death b	ut not rasuit	ing in the u	nderlying o	ausa giv	an in Part I.	236. Did t		-		cause of death? y 4 Unknown
as been sign 2 should be	Completed by								24a. Was perfo	an autor mad?	psy	evailab	utopsy findings le prior to ition of cause h?
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0	Bec	25. Was casa rafarred to medical axaminer?						26. Placa of Dea	ith (Check only o	ne)			
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		27. Mannar of Death  1 ☑ Natural 5 ☐ Panding 2 ☐ Accidant Invastiga		ry Year) 2	8b. Tima of Injury	M 2	28c. Injun Work	yat ⟨? Yas 2 □ No	28d. Dascribe h	ow injur	ry occurre	d	
led in by	Certification:	3 Suicide 6 Could no determin	28a. Placa of inj building, at	ury - At hom c. (Specify)	a, farm, str	eat, factor	y, office		28f. Location (5 City or Tow	itreet an m, State	d Number	r or Rural Ro	uta Number,
ately fill	edicai	29a. Certifier (Check only one)  1 Certifying 2 Madical Ex	Phyaician: To tha best aminer: On the basis of and mannar st	axaminatio	edge, death n and/or inv	occurred vastigation	at the tim , In my o	ne, dete end placa pinion, daath occu	, end dua to the or rred at tha time, o	ausa(s) data and	and man d place, ar	ner as stated nd dua to tha	i. causa(s)
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3	-	P. Richa  30. Name and address of person w	no completed causa of d	aath (Item 2	3a) (Type	Print)	RE	2349		0ct	ober	2, 19	97
)		Patricia Richa					n Sas	uare Driv	ve Bal	timo	re	MD 21	237
	te	31 Dais filed (Month Day, Year)	32. Registr				. Dyl	LUIC DII	, Dal	~ ± III (	,,,,	41	-31



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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND I	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF GEATH	-	3.	TIME OF DEATH
	REBECCA	5	KOI					YEAR	912AM 4
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			ACE (State or Foreign
	318-03-2737 9e. FACILITY NAME (If not institution, give s		84 YRS.	ONTHS DAYS	HOURS MIN,	July 15,	1913	Chica	ago, IL
OR	Hebrew Home Of			Rockv		АТН		t gome	
DIRECTOR	RESIDENCE OF DECEDENT								
R	District Of 10b. COUNT	Y		TOWN OR LOCAT				100	INSIDE CITY
	Columbia None		Was	shingto					YES 2 NO
ZA	10e. STREET AND NUMBER			101	ZIP CODE				T COUNTRY?
FUNERAL	3033 Cleveland Av				20008			.S.A.	
F	11. MARITAL STATUS  1 Never Married 2 Merried	12. WAS DECEDENT EVER I FORCES? 1 YES	N U.S. ARMED	13. WAS OEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	e or No- 1	14. RACE - Black, V	American Indian, /hite, etc.
ВУ	3 ☑ Widowed 4 ☐ Divorced	IF YES, GIVE WAR OR E	ATES		2 NO Specify		i	Specify:	
	15. DECEDENT'S EDU	CATION	16e. DECEOENT'S US	IIIAL OCCUBATIO			<u> </u>		Mite
COMPLETED	(Specify only highest grade	completed)	(Give kind of wor	k done durina mo	st of working	16b, KIND OF BU	SINESS/INDU	STRY	
7	Elementary/Secondary (0-12) 12 Years	College (1-4 or 5+)	Secretary		nting	Printi	ina		
M	17. FATHER'S NAME (First, Middle, Lest)		becretar	YTACCOU					
ပ	Peter Fleures					ME (First, Middle, Malder Williams (		22	
BE	19a. INFORMANT'S NAME (Type/Print)	<del></del>							•
2						loute Number, City or Tox			
	Michael Skol				-	, NW, Wash			
	1 To Buriel 2 Cremation 3 Rem	oval from State cer	b. PLACE AND DATE OF	r plece i			CATION - CI		
	4 Donation 5 Other (Specify)		halom Ceme				Latine	, III	linois
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	Vonald (	. Xtottle	myer			T, NW, WAS			
	23. PART i. Enter the dieeesea, or o	complications that cause	d the deeth. Do not	enter the mo	de of dying, auci	n ea cerdiec or resp	iretory arre	at,	Approximata
	IMMEDIATE CAUSE (Final	List only one ceuse on a	/						Interval Between Onset and Death
	disease or condition resulting in deeth)	. ASPIR,	ATION F	NFUL	MONITIS	OF BOTH	FILLA	(Le	
	resulting in deeth)	DUE TO (OR AS	A CONSEQUENCE OF):	1004.	10,01	01 10011	20(10	43	
z		DEMEN	TIA OF	ALZ	LHFIME	is TY/	DE		
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CERTIFICATION	cause, Enter UNDERLYING CAUSE (Disease or injury	C.							
드	thet initiated eventa	DUE TO (OR AS	A CONSEQUENCE OF):						
표	resulting in death) LAST	d							
	DADT II Other elemiticant condition	an annielbuillen in de de etc.		- CA				1	
NA	PART II. Other aignificant condition	a contributing to desth i	out not resulting in	the underlying	cause given in	Pert I. 24s. WAS AN PERFO		AV	ERE AUTOPSY FINDINGS WILABLE PRIOR TO
ă						1 YES :	2 146		OMPLETION OF CAUSE F DEATH?
M					2		/ ~	1	YES 2 NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	OF DEATH YES	□ NO 🌣	UNCERTAIN	4 🗆 ]		100	
C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	, , ,					
YSI	1 TYES 2 NO	1  Inpatient 2  ER/Out	petient 3 DOA 4	THER: Nursing Hom	e 5 🗆 Residence	6 Other (Specify)			
H	27. MANNER OF GEATH	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME (		URY AT RK?	28d. OESCRIBE HOW	INJURY OCCU	IRED	
ВУ	1 Natural 5 Pending 2 Accident Investigation			M 1 1					
	3 Suicide 8 Could not be	26e. PLACE OF INJURY building, etc. (Spe	- At home, term, atre	et, factory, office		281. LOCATION (Street City or Town, State		r Rural Rout	e Number,
	4 Homicide determined					ony or lown, state	,		1
COMPLETED	290. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my know	riedge, death occurred	at the time, date	end place, and due	to the cause(s) and me	nner ee stated	Č.	
₹		R: On the beels of exemination							nd manner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE		0,						
BE	Allose 1	At Thend	ing thysi	ejan	29c, LICENSE NUN	a & V	290. DATE	SIGNED (M	Orth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	1 /		0100	0 /	100	100	DOK 07,127
- 11			WOULD BE SEEN ALL LIVER PT	ecrc l					
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State of Maryland / Department of Health and Mental Hygiene

30545 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** October 1, 1997 Rose Marie Slaughter 8:50 P.M. /Medicai 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Colonial Manor Senior Assisted Living Lutherville Baltimore County 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funerai** 10 M 2 F Days Hours 213-34-0048 1908 Maryland Director 88 Usual Rasidance of Dacedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Director r 28a-f s Maryland Baltimore County Lutherville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? must be n 1414 Front Street 21093 U.S.A. Funerai 12. Was Decedant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Marriad ò 1 ☐ Yas 2 ☒ No Specify: þ Specify: White 3 ₩ Widowad 4 Divorced Completed 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) Coilaga (1-4or 5+) 4th Grade Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) altimore, Maryland 18. Mothar's Nama (First, Middle, Maidan Sumama) Be out. Pages 1 end 2 should ment of Health and Men 0 Robel George Sophia Eschbach 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health If item 27 is or other tree Francis Richardson Slaughter/Son 151 Casparus Way, Elkton, Maryland 21921 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 10/4/97 Data 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ⊠ Burial 2 □ Cramation 3 □ Ramoval from Stata Department of important: If any injury or once. Gardens of Faith Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice License 22. Nama and Addrass of Facility John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. Approximete Intarval Batween Onsat and Death **Physician** YOUN CARCINOMA /Medical Immediata Cause (Finel disaasa or condition rasulting in daath) Examiner Physiclan/Medical Examiner The law requires that the deeth certificate be executed Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaasa or Injury thet initiated avants resulting in daath) Last and buriel-tran Due to (or as a consequence of): Box 68760. the Dua to (or as a consequance of): for use es P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? ned by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ ate hes been signe page 2 should be 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed certificate 1 ☐ Yes 2 X No 1 Yas 2 No or Attanding Physician: 25. Was case referred to medical Be 26. Piece of Deeth (Chack only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) To 1 Yas 2 No After this the funeral 28e. Data of Injury (Month, Day Year) 27. Mennar of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Panding Invastigation death 2 Accident after death 6 Could not be datarmined 3 ☐ Suicida 28a. Piaca of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 6 4 Homicide 24 hours Hospital 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stetad.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b, Signatura and titia of cartifian 29c. Licansa number 29d. Date signed (Month, Day, Yaar) of deeth (Itam 23a) (Type, Print) OSLER DR. SUIDE 202 TOWSON MD 21204 7401

Ragister's Signature

State Registrar

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Street Francisco

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	22	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician and completely filled in by the filed within 72 hours after death with the State Debt, of Health and Mental Hygliene prior to burial, cremation, or managed.	4
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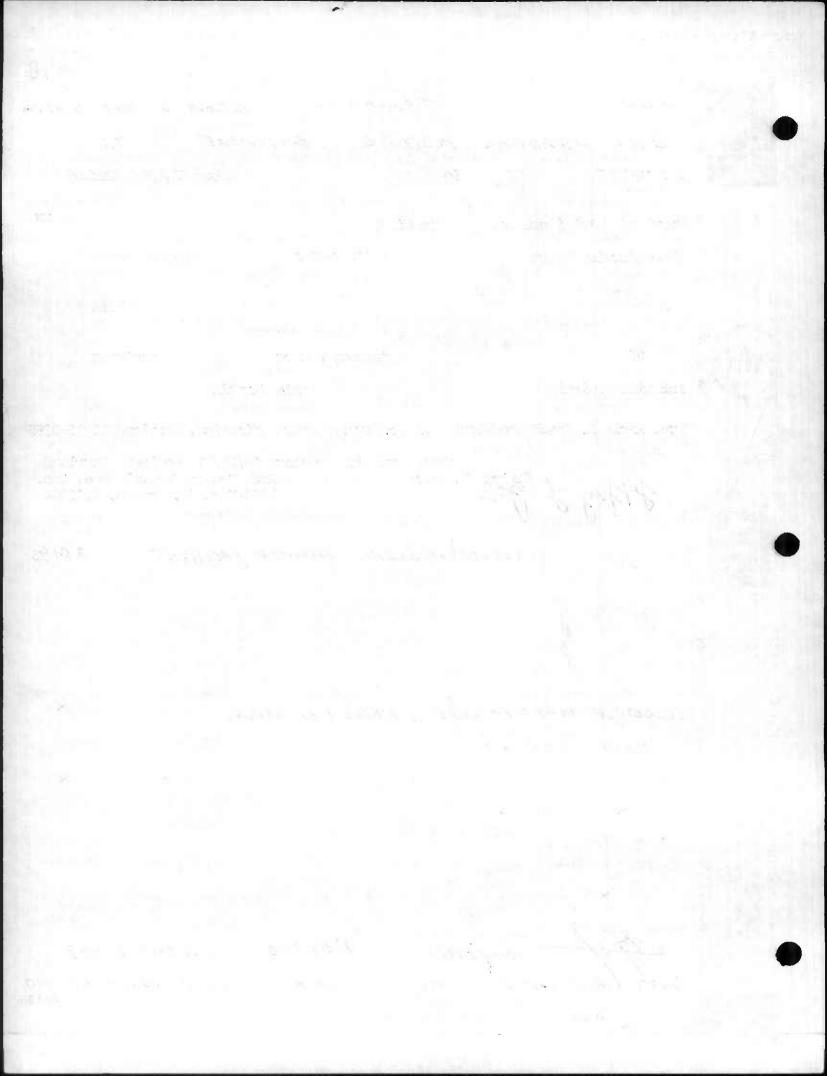
I	FOR STATE REGISTRAR		STATE OF N	MARYLAND /		RTMENT OF			MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First,	-	R.	Savit	h				2. DATE MONTO	OF DEATH	7 /	OYEAR	3. TIME OF DEATH 415000
	4. SOCIAL SECURITY NUMB 219-10-6927	ER	5. SEX	6. AGE (In yrs. les	t birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	-	R 24 HRS.	7. DATE	OF BIRTH h, Day, Year)	917	Count	IPLACE (State or Foreign
TOR	9a. FACILITY NAME (# not in Church Home	Hospi				96. CITY, TOW Baltin			EATH		9c. COU	A	EATH
DIRECTOR	10e. STATE Maryland	10b. COUNTY	imore Co	unty		r, town or Loc	CATION						10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	7241 Gough S	treet					101. ZIP COE 21224				U.S	.A.	VHAT COUNTRY?
BY	11. MARITAL STATUS  1 Never Married 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2 X		If yes,	epecify Cub	en, Mexic	an, Puerto	t? (Specify Yo Rican, etc.)	s or No—	14. RACI Blac Spec	E — American Indian, k, White, etc. "White
PLETED		EDENT'S EDUC y highest grade		(G life.	him kind of	S USUAL OCCUP! work done during ise retired.)		ing	161	Own H		DUSTRY	
BE COMPL	17. FATHER'S NAME (First, M	iddle, Last)	Davids	1			18. MO		AME (First,	Middle, Maide		Ma	.son
TO B	19a. INFORMANT'S NAME (1 Roger Robert	s/Neph		13	3613	Devonb	rook 1	Road	, Bal	dwin,	Mary	land	
	20a, METHOD OF DISPOSIT  Burlel 2 Cremetic  4 Donation 5 Other  21. SIGNATION OF FUNERA	(Specify)		cemetery, cre Meado	AND DATE	of disposition other place)  lige Mem  22. NAME	orial	Par.	ACILITY	Ba	ocation – ltimo		Maryland
	23. PART Enter the d	-	2 Ho	mas	eth Do	6415		ir Ro	oad,	Balti			yland 21206
		aart fallure.	List only one can		D.						piratory sr	TOUL,	Approximate interval Between Onset and Death
TION	Sequentially list condit		. Cerel	OR AS A CONSE	OUENCE O	Cula	r C	RCC	id	ln			t 1 day
ERTIFICATION	cause. Enter UNDERLY CAUSE (Disease or inju- that initiated events resulting in death) LAS	ary T	DUE TO	(OR AS A CONSE	OUENCE (	OF):							
07	PART II. Other algnifica	ant condition	a contributing to	deeth but not	resulting	In the underly	ying cause	given li	Part I.		N AUTOPSY ORMED?	241	D. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICA	DID TOBACCO U		RIBUTE TO CA			ES NO		CERTA	IN 🗆				1 YES 2 NO
HYSICI	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH	O MEDICAL	HOSPITAL: 1 Vinpatient 2	☐ ER/Outpatient :		OTHER:		Rasidence	-	er (Specify) SCRIBE HOW	INJURY O	CUREO	
ВУ	2 Accident	Pending Investigation Could not be	(Month, I	Day, Year)  DF INJURY — At he etc. (Specify)		M 1	WORK? VES 2	□ NO	281. LO	CATION (Stree	t and Numbe		Route Number,
PLETED	4 Homicide	determined	ICIAN: To the best o		eath occur	rred at the time,	data and place	ce, and du		or Town, State		ited.	
E COMPLET	anal						29c. LI	CENSE N	JMBER	_	29d, DA	TE SIGNE	a) and manner as atated.  D (Month, Day, Year)
TO BE	30. NAME AND ADDRESS O			1 . D	EM 27) (Typ	on, Print) XH H	D	17	695	Pa -	1.	chot	Balto.
	ABDALLAH  31. DATE FILEO (MONTH, Day,		ELOU/	AR'S SIGNATURE	HUK	CHI TR	SP.	100	10,	pura	aae	ty	MB 2/231
	061081	1221	A	window-Ma	MACO	3	-					1100	

-	ITEM: 10e 17 19b er 1. Decedent's Neme (First, Middle,	Loot			Death	Reg	g. No.	2 Tim	of Death	
Physician /Medical	VIRGINIA	B. T	ILLMAN			Month OCTOBER	Dey 5	Year 47	1:1=12	
kaminer	4a. Facility Name (If not institution,				4b. Clty, Town, or Lo		4c. County			
	Charles Town 5. Social Security Number		Y ge (In yrs. lest birthday)	If Under 1 Year	Baltimo			altimore	to or Foreign	
al or	213-10-3660 Usual Residence of Decedent	1□ M 212 F	86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey, Oct. 16	(Pear) , 1910	9. Birthpiaca (Ste Country) Marylar	nd	_
	10a. State 10b. County	1 1	10c. City, Town or Lo	cation				1 1 1 1 1 1 1 1	e City Limits	
Director		altimore	Balti						res ZEINO	ļ.
	10e. Street and Number	des Tens B	8122	10f. Zip Code	220	10	g. Citizan of W			
eral	707 Maiden Cho	12. Was Dacedent			.228	oify Vee or No-	U.S.	- Americen Indian		
by Funeral	11. Marital Status  1 Naver Marriad 2 Marrie  3 Widowed 4 Divorced	Armed Forcas	No	f Yes, specify Cub	dispenic Origin? (Spe an, Maxican, Puarto Specify:	Ricen, etc.)		k, Whita, etc.		
	15. Decedent's (Specify only highest	Education arede completed)	16a. Dece	dent's Usuei Occup	pation during most of works	ina 1	6b. Kind of Bu	sinass/Industry		
Completed	Elementery/Secondery (0-12)	College (1-4or	5+) life.	DO NOT use retire	during most of works d) Secretary		Cles	rical		
	17. Father's Name (First, Middle, L.	ast)			10 Mathada Name	(Einst Middle 14	aiden Cumem			
o Be	Fulton C. Barro				bovel	la A. Sc	ott			
-	19e. Informant's Name/Relationshi	p (Type, Print)	19b. Mallin	ng Address (Street	end Number or Rura	al Route Number,		Steta, Zip Code)	21228	
	Edwin Eugene Ti	llman/Husba	nd 707 Ma	aiden Cho	ice Ln. A	pt. 8122 pt. <del>8112</del>	Caton	sville, N	Md.	
	20a. Method of Disposition 1   □ Burial 2 □ Cramation 3	Ramoval from State	20b. Place of Dispo cemetery, crer	sition (Neme of netory or other ple	ce)	Date 2	0c. Location -	City or Town, State	В	
	4 Donation 5 Other (Spe			Zallev Me	m. Grd.10	/8/97 Ti	monium	. Maryla	nd	
Milks	21. Signeture of Funeral Service Li	Rust	22	Name and Address  So York	ess of Facility Ru	ck Towso Towson,	n Fune:	ral Home		
	23a. Pert1. Enter the disease, or conshock, or heert failure. List o						st,	Approxi intervel Onset e	mate Between and Deeth	
al er	immediata Ceusa (Final disease or condition	LA	RGE CE	LL L'	YMPHO	MA		78	PARS	
	resulting In deeth)		Due to (or as e consec							
Examiner	Compandia the Bad and distance	b	Dua to (or as a consec	mance of).						
edical Exa	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events	c	Dua to (or as a conseq							
	resulting In death) Last	d	Dua to (or as a conseq	uance ory.						
Physician/M	Pert II. Other significant condition	a contributing to death t	out not resulting in the u	nderlying ceuse gi	ven in Pert i.	23b. Did tob	acco uae con	tributa to the cau	sa of death?	
by Phy	CONGESTIVE	HEART	FAILURG			1 🗆 Ye	200 No	3 Probably	4 🗌 Unknown	
Completed b						24a. Wes an perform	eutopsy ed?	24b. Were autop available pr completion of death?	ior to	
E						1 ☐ Yes	200 No	1 🗆 Yes		
BeC	25. Was cese referred to medicei				28. Piece of Deat					
TOE	examiner? 1 ☐ Yes 2 No	Hospitel: 1 Inpati	ent 2 ER/Outpatier	nt 3 DOA Ott	ner: 42 Nursing Ho	me 5 Resider	nce 8 Othe	or (Specify)		
	27. Menner of Deeth  1 Naturel 5 Pending 2 Accident investiga		ury 28b. Time o injury	Wo	ry et rk? Yes 2 \( \text{No} \)	28d. Describe how	v injury occurr	bed		
Sertific	3 ☐ Suicide 6 ☐ Could no determin	ed Zoe. Piece of fit	jury - At nome, ferm, str tc. (Specify)	eet, factory, office	7	28f. Location (Stre City or Town,	eet end Numbe Stete)	er or Rural Route i	Vum ber,	
edicai Certification:			of my knowledge, death of examinetion end/or in lated.						se(s)	
Medical Certifical	29b. Signature and title of certifier	Jul	wslow	29c. Licens	sa number			(Month, Day, Yea		
	30. Neme and eddress of person w	ho completed ceuse of a		Print)		LANE		1228		
State strar	31. Date filed (Month, Dey, Year)  OCT 0 8199	320 Regist	rar's Signeture	02.		746				

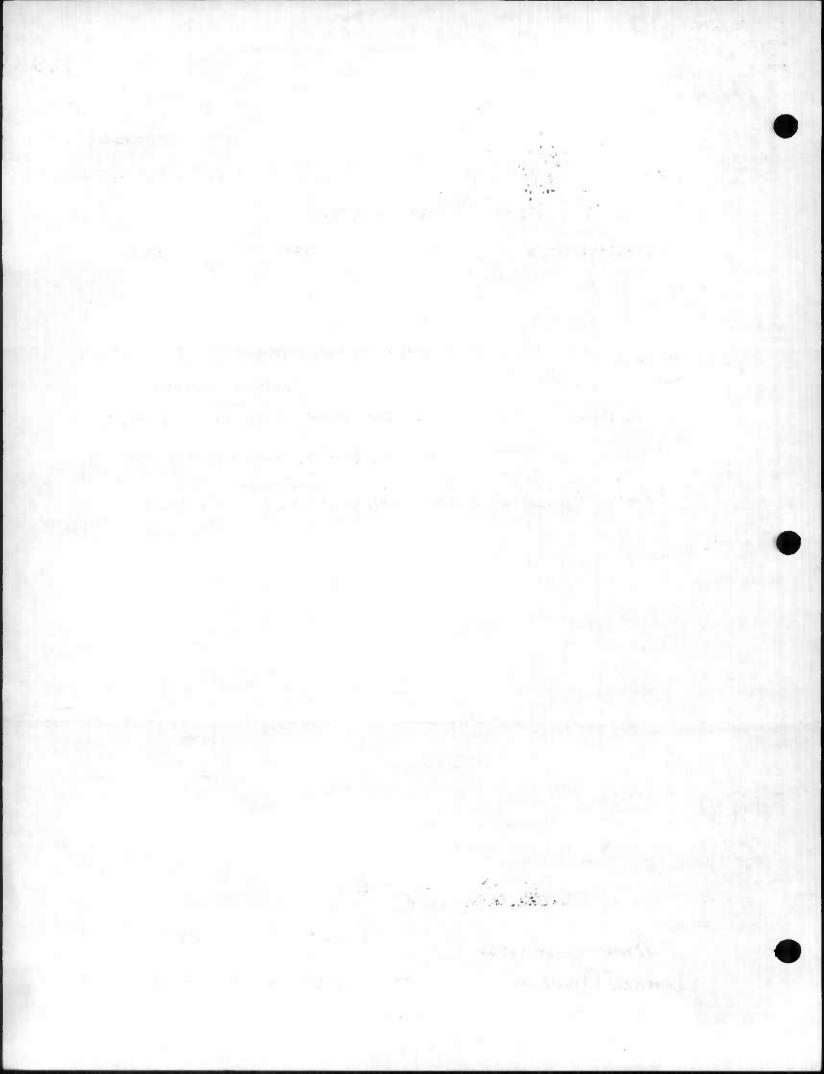
Falls 0 Too

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

To Re Completed by Funeral Director	5. Social Security Number 213-46-3227 Usual Residence of Deced 10e. State 10b. ( Maryland F 10e. Street and Number 27 Wondervie 11. Marital Status 1 Navar Married 2 3 Widowed 4 Di 15. Di	6. Say 1 County Baltimo  W Cour Married vorced seedent's Edu highest grade 0-12) hiatis	ore Co.	7. Age (In yrs 90 10c. C	ity, Town or Lo  Timoniu  16e. Deceding fire and the control of th	Months  cation  10f. Zip 0  210  Was Dacede f Yes, speci	Tyaar Days  Code  93—: ant of H fy Cube	Ab. City, Town, or  BALT  If Undar 24 Hrs  Hours Min.  3365  Ilspanic Origin? (San, Mexican, Puari	8. Dete of Big (Month, De October	th 4c. County  rth (y, Year)  C 28,190  10g. Citizen of W	N/A  9. Birthpleca (country) 6 Turks  10d. tns 11	side City Limits ☐ Yes 2010
To Re Completed by Funeral Director	5. Social Security Number 213-46-3227 Usual Residence of Deced 10e. State 10b. ( Maryland F 10e. Street and Number 27 Wondervie 11. Marital Status 1 Navar Married 2 3 Widowed 4 Di (Spacify only) Elementery/Secondery ( 06 17. Fether's Nema (First, Mantonios Mar 19a. Informent's Name/Re Mrs. Maria F 20a. Method of Disposition 1 Struin 2 Cren	6. Say 1 County Baltimo  W Cour Married vorced seedent's Edu highest grade 0-12) hiatis	ore Co.  12. Was Dece Armed For 1 U Yes, Gry Yaar or Deceation a completed)	7. Age (In yrs 90 10c. C	. lest birthday) Yrs. ity, Town or Lo Timoniu  J,S. 13. 1	Months  cation  10f. Zip 0  210  Was Dacede f Yes, speci	Days  Code  93—: ant of H fy Cube	BALT/ If Undar 24 Hrs Hours Min.  3365  Ilspanic Origin? (San, Mexican, Puari	8. Dete of Big (Month, De October	10g. Citizen of V United	N/A  9. Birthpleca (country) 6 Turks  10d. tns 11	BY side City Limits □ Yes 2⊠No
To Re Completed by Funeral Director	5. Social Security Number 213-46-3227  Usual Residence of Decer 10e. State 10b. (  Maryland I  10e. Street and Number 27 Wondervie 11. Marital Status 1 Navar Married 2  3 Widowed 4 Di  (Spacify only Elementery/Secondery ( 06  17. Fether's Nema (First, Martonios Mar  19a. Informent's Name/Re  Mrs. Maria I  20a. Method of Disposition 1 Weurial 2 Cren	6. Sar flent County  Baltimo  W Cour  Married vorced eccedent's Edu highest grade 0-12)  Aiddle, Last) niatis	ore Co.  12. Was Dece Armed For 1   Yes, Giv Yaar or Deceation e completed)	7. Age (In yrs 90 10c. C	. lest birthday) Yrs. ity, Town or Lo Timoniu  J,S. 13. 1	Months  cation  10f. Zip 0  210  Was Dacede f Yes, speci	Code 93-: ant of H fy Cube	If Undar 24 Hrs Hours Min.  3365  Ilspanic Origin? (San, Mexican, Puari	8. Dete of Bir (Month, De October	10g. Citizen of V United S 14. Rec Bleck	9. Birthpleca (Country) (Country) (10d. tns 10d.	BY side City Limits □ Yes <b>2⊡</b> No
To Re Completed by Funeral Director	213-46-3227  Usuel Residence of Deced 10e. Stete 10b. ( Maryland I 10e. Street and Number 27 Wondervie 11. Marital Stetus 1 Navar Married 2: 3 Widowed 4 Di (Spacify only Elementery/Secondery ( 06 17. Fether's Nema (First, I) Antonios Mar 19a. Informent's Name/Re Mrs. Maria I 20a. Method of Disposition 1 XBurial 2 Cren	ever description of the state o	Dre Co.  12. Was Dece Armed For 1   Yes, Giv Yaar or Deceation   completed)	90 10c. C	Yrs. ity, Town or Lo Timoniu  J,S. 13. 1	Months  cation  10f. Zip 0  210  Was Dacede ff Yes, speci	Code 93-: ant of H fy Cube	Hours Min.  3365  Ilspanic Origin? (San, Mexican, Puari	(Month, De October	10g. Citizen of V United S 14. Rec Bleck	10d. tns 10d. tns 11c Whet Country? States 20 - American Indek, White, etc.	Sy side City Limits ☑ Yes <b>②</b> ØNo
To Re Completed by Funeral Director	10e. Stete 10b. I Maryland I 10e. Street and Number 27 Wondervie 11. Marital Stetus 1 Navar Married 2 3 Widowed 4 Di (Spacify only Elementery/Secondery (O6 17. Fether's Nema (First, Martonios Mar 19a. Informent's Name/Re Mrs. Maria I 20a. Method of Disposition 1 Wauria 2 Cren	County  Baltimo  W Cour  Married vorced  eccedent's Edu highest gradu 0-12)  Aiddle, Last)  aiatis  lationship (Ty	12. Was Dece Armed Foi 1 Tyes If Yes, Giv Yaar or De cation e completed)	odent Evar in I rces? 2 M No a a tas:	Timoniu  J.S. 13. 1  16e. Deced	10f. Zip of 210 Was Dacedif Yes, specific Yes 2	93–: ant of H fy Cube	lispanic Origin? (S en, Mexican, Puar	pecify Yes or No o Rican, atc.)	United 1	Whet Country? States	Yes 2⊖KNo
Toke Completed by Funeral Di	10e. Street and Number 27 Wondervie 11. Marital Stetus 1 Navar Married 2 Spacify only Elementery/Secondery 06 17. Fether's Nema (First, Name/Re Mrs. Maria F 20a. Method of Disposition 1 Surial 2 Cren	Married vorced eccedent's Edu highest grade 0-12) Aiddle, Last)	12. Was Dece Armed Foi 1 Tyes If Yes, Giv Yaar or De cation e completed)	odent Evar in I rces? 2 🔯 No a atas:	J,S. 13. \	10f. Zip 0 210 Was Daceda if Yes, speci	93–: ant of H fy Cube	lispanic Origin? (S en, Mexican, Puar	pecify Yes or No o Rican, atc.)	United 1	Whet Country? States De - American Indek, White, etc.	
Toke Completed by Funeral Di	27 Wondervie  11. Marital Stetus  1 Navar Married 2  3 Widowed 4 Di  (Spacify only  Elementery/Secondery (O6  17. Fether's Nema (First, Mantonios Mar  19a. Informent's Name/Re  Mrs. Maria 7  20a. Method of Disposition  1 Surial 2 Cren	Married vorced ecedent's Edu highest grade 0-12)  Middle, Last)  iatis  lationship (Ty	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Yaar or De cation e completed)	rces? 2⊠No a atas:	16e. Deced	210 Was Dacede f Yes, speci	93–: ant of H fy Cube	lispanic Origin? (S en, Mexican, Puar	pecify Yes or No o Rican, atc.)	United 1	States Se - American Ind ck, White, etc.	ien,
To Re Completed by Funeral	11. Marital Stetus  1 Navar Married 2   3 Widowed 4 Di  15. Di  (Spacify only)  Elementery/Secondery (  06  17. Fether's Nema (First, II  Antonios Mar  19a. Informent's Name/Re  Mrs. Maria II  20a. Method of Disposition  1 XBurial 2 Cren	Married vorced ecedent's Edu highest grade 0-12)  Middle, Last)  iatis  lationship (Ty	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Yaar or De cation e completed)	rces? 2⊠No a atas:	16e. Deced	Was Daceder If Yes, special I Yes 2	int of H fy Cube	lispanic Origin? (S en, Mexican, Puar	pecify Yes or No o Rican, atc.)	o- 14. Rec Bled	ce - American Ind ck, White, etc.	lien,
To Re Completed by	1 Navar Married 2 3 Widowed 4 Di 15. Di (Spacify only) Elementery/Secondery ( 06 17. Fether's Nema (First, III) Antonios Mar 19a. Informent's Name/Re Mrs. Maria II 20a. Method of Disposition 1 XBurial 2 Cren	Married vorced ecedent's Edu highest grade 0-12)  Middle, Last)  Liatis  Hationship (Ty.)	Armed For 1 Yes If Yes, Giv Yaar or Decation a completed)	rces? 2⊠No a atas:	16e. Deced	1 ☐ Yes 2	₩ No		pecify Yes or No o Rican, atc.)		ck, White, etc.	lien,
Toke Comp	(Spacify only  Elementery/Secondary (  06  17. Fether's Nema (First, I  Antonios Mar  19a. Informent's Name/Re  Mrs. Maria I  20a. Method of Disposition  1 XBurial 2 Cren	highest grade 0-12) Middle, Last) Diatis	e completed)	-4or 5+)	(Give	dent's Usuel	0				White	
Toke Comp	Elementery/Secondery ( 06  17. Fether's Nema (First, N Antonios Mar  19a. Informent's Name/Re Mrs. Maria F 20a. Method of Disposition 1 XBurial 2 Cren	0-12)  Middle, Last)  niatis  Hationship (Ty		-4or 5+)	life. L		done	etion during most of wo	trina	16b. Kind of Bu	usinass/Industry	
Total Total	17. Fether's Nema (First, MANTONIOS MAR  19a. Informent's Name/Re  Mrs. Maria 7  20a. Method of Disposition  1 XBurial 2 Cren	iatis Hationship (Ty				DO NOT use	retired	d)	ning.			
To Table	Antonios Mar  19a. Informent's Name/Re  Mrs. Maria 7  20a. Method of Dispositior  1 XBurial 2 Cren	iatis Hationship (Ty				Facto	ry V	Worker	(57-4 8 87 4 41-		stress	
	19a. Informent's Name/Re  Mrs. Maria 7  20a. Method of Dispositior 1 □XBurial 2 □ Cren	lationship (Ty								, Meiden Sumen	na)	
1	Mrs. Maria 7 20a. Method of Disposition 1 DXBurial 2 Crem		ne Print)		19h Mailir	a Addrose	(Street	Maria St		as City of Town	State 7in Code	1
o h		netion 3 🗆 R	emovei from S	20b. State	Pleca of Dispo cemetery, cren reek Or	sition (Nem netory or oti thodo	e of ha <i>r pled</i> X C	emetery!	10/10/97		wn, Mary	land
2000	21. Signeture of Funeral S	ervice Licanse	Jeffr	ey L.	Gair 22	. Nama and	Addres	ss of Facility Rue		on Funera Rd. Tow		
ner r	Immediate Ceuse (Finel disasse or condition resulting in deeth)  Sequentielly list conditions	a	CER.	Due to	or es e consequence or es e consequence de conseque	quence of):	A	werrys m	Acci	IDENT	3	0445
ledical	Sequentielly list conditions if any, leeding to immedie cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest		1	Due to (	or es e conseq	uenca of):						
d by Physician/M	Pert II. Other significant c	onditions con	tributing to de	ath but not re	sulting In tha ur	nderlying ca	usa giv	en in Pert I.	23b. Did	tobacco use co	ntributa to the c	ause of death?
by Physician/N	CONGESTIVE	HEA.	RTFA	ILURI	E, A	TRIA	LF	IBRILLAT	TON, 10	Yes 2 No	3 Probably	Unknow
pieted	AORTIC	STE	NOSI	٢					24e. Wes	s en eutopsy ormed?	24b. Were eu aveileble completi of death	prior to on of causa
To Be Comp									10	Yes 2 No	1 🗆 Yes	No
2 8 2	25. Was case referred to rexeminer?	_						26. Plece of De	oth (Check only	one)		
- I	1 Yes 2 No	H			ER/Outpetien			4 Li Nursing r		Idence 6 Oth		
0	2 Accident	Pending Investigation Could not be		of Injury h, Dey Year)	28b. Time of Injury	М		y et k? Yes 2 □ No		how injury occur		
Certif	4 Homicide	determined	buildir	of Injury - At I	nome, ferm, str ify)	eet, fectory,	offica			(Street end Numb wn, Stete)	per or murei mout	e rvum <i>per</i> ,
edicai	29a. Certifier 1 ☑ C (Check only 2 ☐ Moone)	erttfying Phys edical Examir	ner: On the ba and menn	sls of examin	owledge, deeth etion end/or inv	occurred e vestigetion,	t the tim	ne, dete end pleca pinlon, death occu	, end due to the rred et the time,	ceuse(s) end me date end place,	enner es steted. and due to the c	euse(s)
	29b. Signature and title of	perioder					-	e number		29d. Dete signe	d (Month, Dey, )	'ear)
2	Zg			ESTAI			0	9308		OCTOBER	6,199	7
2 3	30. Name and eddress of p	erson who co			m 23e) (Type,	Print)	4RA	WAU E	DULEVAS	RO, BA	HTTMOR	E MO



Physici		rt I 27 28a-f per M 1. Decedent's Name (First, Middle	e, Last)			rtificate of		2. Date of De Month	Reg. No. eath Day	Year	3. Time of Deeth
/Medic Examin	ai	SUSAN 4e. Facility Name (If not Institution		THEISS mber)			4b. City, Town, or	OCTOB		997 of Death	12:15 A
		4640 PARKSIDE	-			M. Davies d. W	BALTIMOR			IMORE (	_
Funeral Director		5. Sociel Security Number 212–48–6385	6. Sex 1 □ M 2 □ F	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Deys		(Month, D	27,1948	9. Birthplac Country Mary	e (Stete or Foreign land
show od at	70	Usual Residence of Decedent  10a. State 10b. County  Maryland Balti	more City	10c. 0	City, Town or Lo	cation imore Ci	+ 1/			10d.	Inside City Limits
or 28a-f show	Director	10e. Street and Number	more city		Dair	10f. Zip Code	СУ	T	10g. Citizen of V	Albert Country	1xxYes 2□No
23a or		4640 Parkside	Drive			Tor. Zip code	21206		USA	mai Country	£
natural, or items :	by Funeral	11. Marifel Status  1 □ Never Married ②  Married 3 □ Widowed 4 □ Divorced	12. Was Dece Armed Fo  1  Yes If Yas, Giv	rces? 2 💢 No /e		Was Decedant of If Yes, specify Cub 1 ☐ Yes 2xxx0	Hispanic Origin? (Span, Maxican, Puer Specify:	Specify Yes or Note Ricen, etc.)	o- 14. Rec Blac Specify	e - American ck, White, etc	
Scal E		15. Decedent	's Educetion		16e. Dece	dent's Usual Occu	pation during most of wo	deina	16b. Kind of Bi	usiness/Indus	itry
the Me	Completed	Elamantary/Secondary (0-12)	Collega (1	-4or 5+)					0.16		
T.	Be Co	12 years 17. Fether's Name (First, Middle,	N/A		Medic	al irans	cription:		Seli-I	Employe	ed
atic ev	To B	Robert L. Cohe	n				Shirle	ey Schwa	rtzman		
27 is marked of traumatic eve		19a. Informant's Name/Relationsl Paul P. Theiss	nip (Type, Print)				kside Dr:				
other		20a. Method of Disposition			Place of Dispo	sition (Neme of	T	Date	20c. Location -		
int: If i		XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State		netory or other ple ark Ceme	tery 10-	9-1997	Baltimo	ore. Mo	d.
Important: If itam 27 is any Injury or other trau once.		21. Signature of Foreral Service i	icegaee Of	10/4	L		ess of Facility Uneral H ir Rd. Ba				
Medical and physician and the burial-transit	ai Examiner	Immediate Causa (Final disease or condition resulting in daath)  Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Undarlying Causa (Disease or injury	α	ASTIC BA	(or as a consac G PLACED (or es e consec	OVER HEAD					
attending phys	Physician/Medical	thet initiated events resulting in death) Lest	d	Due to	(or as a conseq	uence of):					
20	ysici	Part II. Other significant condition	ns contributing to de	eath but not re	esulting in the u	nderiying ceusa gi	ivan in Part I.	23b. Dld	tobacco use co	ntribute to th	e cause of deeth?
be detech	by Ph							10	Yes 2□ No	3 Probab	dinknown
2 should	Completed								an autopsy ormed?	availa	autopsy findings ble prior to letion of ceuse ath?
r. page								D <del>3</del>	Yes 2□No	NEW Y	es 2 No
	o Be	25. Was cese referred to madical exeminer? 1 ▼Yes 2 No	Hospital:	npatient 2[	☐ ER/Outpatier	nt 3 DOA Ot	her:	ath.(Check only	one) idence 6 □Oth	er (Snecify)	
N/	Dn: T	27. Manner of Death	28a. Date	of Injury h, Day Yeer)	28b. Time of				how injury occur		
To the Funeral Director: completely filled in by the	Certification:	2 Accident Investig 3/0X/Suicide 6 Could r 4 Homicida determi	etion found 1		found mi home, farm, str	idn ght 1 eet, factory, office	Yes 3/1/2/No	28f. Location City or To	put plasti (Street end Numb wn, Stete) 4640 e, Marylan	Parksio	ver her head outa Number, de Drive,
Funer Funer stely fill	edicai	29a. Certifier 1☐ Cartifying (Check only one)	Physician: To the examiner: On the be and mann	isis of examir	nowledge, daeth netion end/or inv	occurred at tha tivestigation, in my	ima, data and plece opinion, daath occi	e, and dua to tha	cause(s) and ma	inner es state	ed. a causa(s)
To the comple	Mec	29b. Signatura and fittle of certifier	2 Christ	MQ-		29c. Licen	se number C.M.E		29d. Date signe OCTOBER	06,19	
Sta	te ar	T TIV		egistrar's Sign	111	Penn St	reet, Bal	ltimore,	Marylar	nd 2120	01



State Registrar

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Stephen S, 31. Date filed (Month, Day, Year) OCT 0 8 1997, Radentz MP

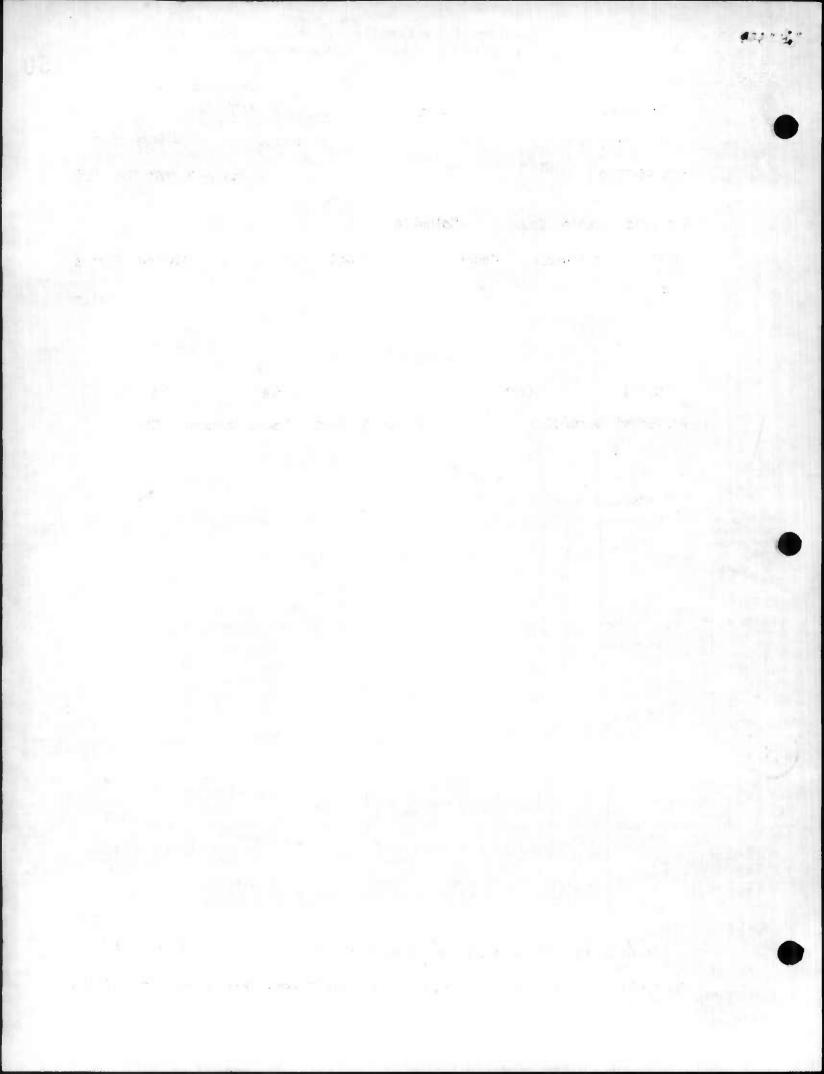
29b. Signature and titla of certifier

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year) OCTOBER 2,1997

29c. License number

O.C.M.E.



WRC 97-5658-510 OTIS WH:

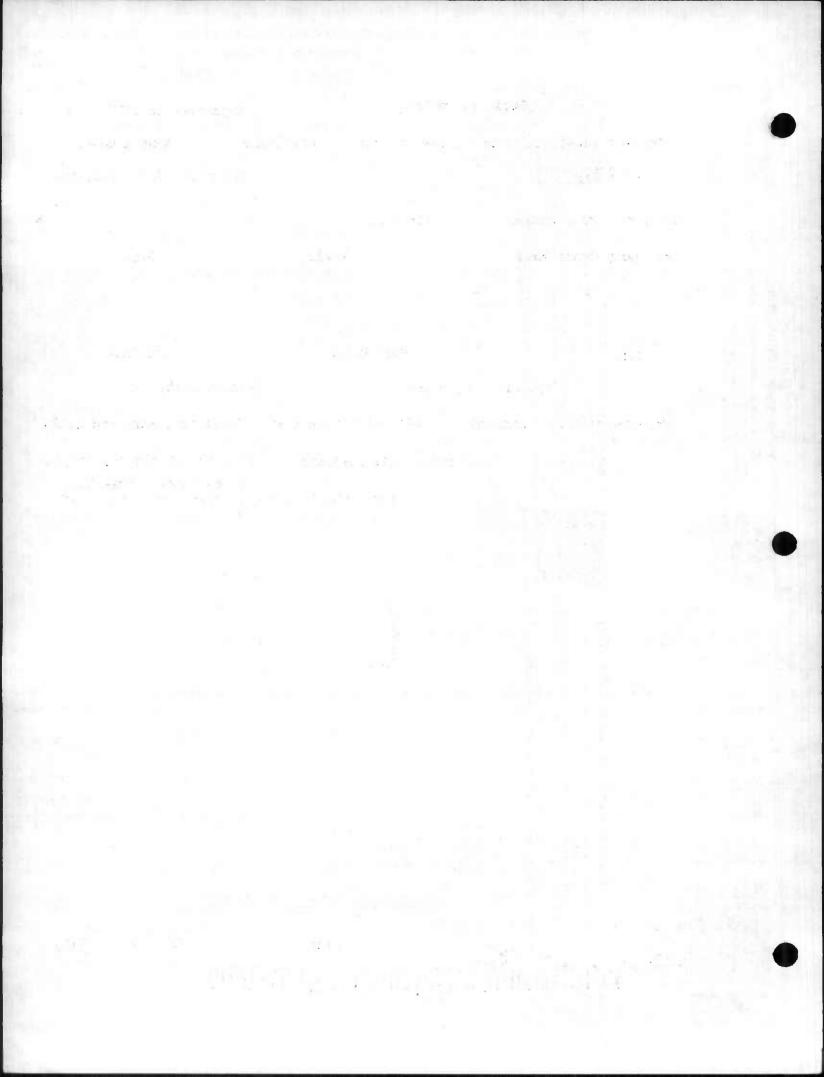
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 30551

ITE			Cer	tificate of Death		Reg. No.	,	00001			
Physic /Medi		1. Decedent's Name (First, Middle, La	. White SR	2	2. Date of Dea Month		Year	3. Time of Death 3:15 P.M.			
Examir			GHTS AVE. APT. 302		TIMORE	1	AV				
Funeral Director		5. Social Security Number 6. S 202 - 28 ~ 2035  Usual Residence of Decedent	7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)	If Undar 1 Yaar If Undar 24 Hrs Months Days Hours Min.	8. Data of Birt	- 37	Coun	lace (State or Foreign try) CT. CAROLIN			
the Maryland 28a-f show	ctor	10a. State 10b. County	10c. City, Town or Loc	imore			11	0d. Inside City Ltmits			
th with 23a of	rai Director	3317 Liber	ty Height Ave	10f. Zip Code 21216		10g. Citizen of V	What Coun	try?			
5-0020 72 hours efter dea natural; or Items	d by Funerai	11. Marital Status 1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ØDivorced	1 X Yas 2 □ No	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puar Yes 2 DNo Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	ck, White, or				
21215- d within 72 giene. r than "nat	Completed	15. Decedent's Ec (Specify only highest gra	ducation de completed)  Coilege (1-4or 5+)  16a. Deced (Give life, D	ent's Usual Occupation kind of work done during most of wo DO NOT use retired) OV + Worker		16b. Kind of Br	De	fence			
be fill H doth	To Be C	17. Father's Name (First, Middle, Last)	Thite	Bu	ma (First, Middle,	Tho	mps				
Baltimore, Maryle permit. Pages 1 end 2 should Department of health and Mer Important: If hen Z? Is marke any injury or other traumate once.		20e. Method of Disposition  1 Buriai 2 Oremation 3  4 Donation 5 Other (Specification 2)  21. Signature of Funeral Service Licer	SP. (Son) 230  Removal from State 20b. Placa of Dispose cemerlery, crem Metro  see 22.	Cremotory  Nama and Address of Facility E	10/9/97 10/9/97	n Town 20c. Location Parti	ship city or to	Detroit, wn, State Mary b			
Physician /Medical		Immediate Cause (Finei	plications that causad the death. Do not ente one cause on each line.	er the mode of dying, such as cardia	c or respiretory er	rest,		Approximate Interval Between Onset and Death			
Examiner	ner	disease or condition resulting to death)	Due to (or es e consequ	uenca of):	01	80-38	>				
50, se execute sian and surial-trans	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):							
Box 68760	//Medicai	that initiated events resulting in death) Lest	Due to (or es a consequent d.	uenca of):							
P.O.	pleted by Physician	by	by	Completed by Physician	Part II. Other significant conditions of	ontributing to death but not resulting in the un	nderlying cause given in Part I.		obacco use co ∕es 2□ No		the cause of death
Records, w requires the speed signer and speed signer and speed signer and speed signer and speed spee							24a. Was perlo	an autopsy rmed?	ava	are autopsy findings aliabte prior to mpletion of cause death?	
	Be Con	25. Was case referred to medical		26 Place of Da	ath (Check only o		1 [	Yes 2□ No			
of Vital	2	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ inpatient 2 ☐ ER/Outpetient	0 3□ DOA Other: 4□ Nursing	lome 5 N Resid	lence 6 Oth		0			
Ming After fune	Certification:	27. Menner of Death  1 SNaturel 5 Pending  2 Accident investigation  3 Sutcide 6 Could not be		28c. Injury et Work?  M 1 Yes 2 No	28d. Describe						
Divisio To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fo		4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	ber or Rura	I Route Number,						
To the Hospital of within 24 hours of To the Funeral D completely filled in	Medicai	29a. Certifier  (Check only one)  1☐ Certifying Ph  2☒ Medical Exam	yaician: To the best of my knowledge, death piner: On the basts of examination and/or thy end manner stated.	occurred at the time, date and place estigation, in my optnion, death occu	e, and dua to the curred et the time,	cause(s) and me date end piace,	enner es st end due to	eted. the cause(s)			
To the within To the comp	M	29b. Signatura and the of certifier	2	29c. License number O.C.M.E.		29d. Date signe					
0,		30. Name and a stress of person who	pluted cause of death (item 23a) (Type, F								
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Street, Baltimo	re, Mary	land 21	.201				
3 - 11		WU1 0 8 199/	June waydoon Mandall	0							

State of Maryland / Department of Health and Mental Hygiene 97 30552

					Certifica	ite of	Death		R	eg. No.	,	00002	
· · · · · · · · · · · · · · · · · · ·		1. Decedant's Nama (First, Middia, Las							2. Data of Deat Month	th Day	Year	3. Time of Death	
Physician /Medical		Doris R. Wehberg					Septemb			1:20 P			
xaminer	-	la. Facility Nama (If not institution, give	a street and number)				4b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
	ų.	Genesis Elderca			T	-	Balti			Anne			
ineral ector		212 20 2211	ax 7. Ag □ M 2XF	a (In yrs. last bi	Yrs. If Unc Month	ar 1 Yaa s Days		Min.	6. Data of Birth (Month, Day, March 2	Year) 1,1929	9. Birthplaca (Stata or Foreign 1929 Maryland		
ž == 3	Usual Rasidanca of Dacedent  10e. Stata 10b. County 10c. City, Town or Location 10									Od. Inside City Limits			
edical Examiner must be notified at letted by Funeral Director	Maryland Anne Arundel Baltimore										1 ☐ Yas 2 ☑ No		
Director	3	10e. Street and Number				ip Coda	-		1	0g. Citizen of \	What Cour	ntry?	
M D		611 Holy Cross H	Road			212	25			U.S	5.		
/ Funeral		11. Maritai Status 1 □ Navar Married 2 ☑ Married	12. Was Decedant   Armed Forces?  1  Yas 2  II		in U,S.  13. Was Decedant of Hispanic Origin? (Specify Yas or Nif Yas, specify Cuban, Maxican, Puarto Rican, atc.)  1  Yes 2 XNo Specify:				ecify Yas or No- Rican, atc.)		ck, Whita,		
d by		3 Widowed 4 Divorced	Yaar or Datas:		12 100		opeany.			Specily	MITTE		
Completed		15. Decedant's Ed (Spacify only highast gra	lucation da complated)	16a	. Decedant's Us (Giva kind of s	vork done	a during most	t of worki	ing	16b. Kind of Businass/Industry		tustry	
amo		Elementery/Secondary (0-12)	Collega (1-4or 5	+)	Home Ma		ed)			Own	Цото		
ပိ		12th 17. Fathar's Nama (First, Middle, Last)			HOME PA	AVET	18 Moths	ar'e Name	(First, Middle, I				
BeC			rederick (	Tri erso	n		10.100110		tella S		, a,		
P		19a. Informant's Name/Ralationship (				ss (Strae	at and Number		I Routa Number		State Zir	Code1	
To		Francis Wehberg			11 Holy				Baltimo				
		20a. Mathod of Disposition	,	20b. Placa o	f Disposition (A	ame of		-		20c. Location -			
once	ı	1 ☐ Burlai 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Hill Cemetery			0/2/97 Baltimore, M			Maryland			
	-	21. Signeture of Funarai Sarvice Licen		Cedar	1		ass of Facilit	h.					
once		V/1- 50	7 -	6.					Gonce F				
	+	23a. Part 1. Enter the disease, or conflications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, Approximate interval Between											
e as the buriel-transit  Medical Examiner		Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated avants rasulting in death) Last	C		consequence of								
cian/Med													
Phys		Part ii. Other eignificant conditione or	ontributing to death bu	at not rasuiting i	n tha undarlying	causa g	iven in Part i		23b. Did to			the cause of death bably 4 Unknow	
Completed by			24a. Was an perform						rmed? availab		ara autopsy findings allable prior to impletion of cause daath?		
E									1 🗆 Ye	as 2AO No		Yas 20 No	
Be Com		25. Was casa referred to medical					26 Piaca	of Death	(Check only on			- 100	
To B		axa <i>m</i> inar? 1 ☐ Yas 2 ☑ No	Hospitai: 1 ☐ inpatle	nt 2 ER/O	utpatient 3 1	OOA O	thor		ma 5 Raside		ar (Snecil	iv)	
ä		7. Mannar of Death	28a. Data of injur	y 26b.	Tima of				26d. Dascribe ho			*/	
Certification:		1 Neturel 5 Panding (Month, Day Year) injury Work? 2 Accidant Invastigation 3 Suicida 6 Could not be							261. Location (Street and Number or Rural Routa Number,				
ie t		4 Homicide	building, ato	. (Specify)					City or Town	n, Steta)			
edical (		29a. Certifier 1 Certifying Ph	ysician: To the best of inar: On the basis of and mannar sta	axamination ar	e, death occurre nd/or invastigation	d at tha ton, in my	tima, deta an opinion, dea	d piace, a	and due to the ca ed et the time, d	ausa(s) and me ate and pieca,	end dua to	tated. the cause(s)	
Medical Certification: 7	29b. Signature and title of certifier  29c. Licansa number								29d. Data signed (Month, Day, Year)  / 0 - 0 / - / 5 9 7				
	400	O. Name and address of parton who o	completed cause of de	eath (item 23e)	(Type, Print)	icur	n. Mi	)2	1040	-			
State	3	31. Data filed (Month, Day, Year)	32. Registre	ar's Signatura	HIII	I	11.10	) ) (	.0 10				
gistrar		OCT 0 8 1997	L.O.DK	idson Pan									
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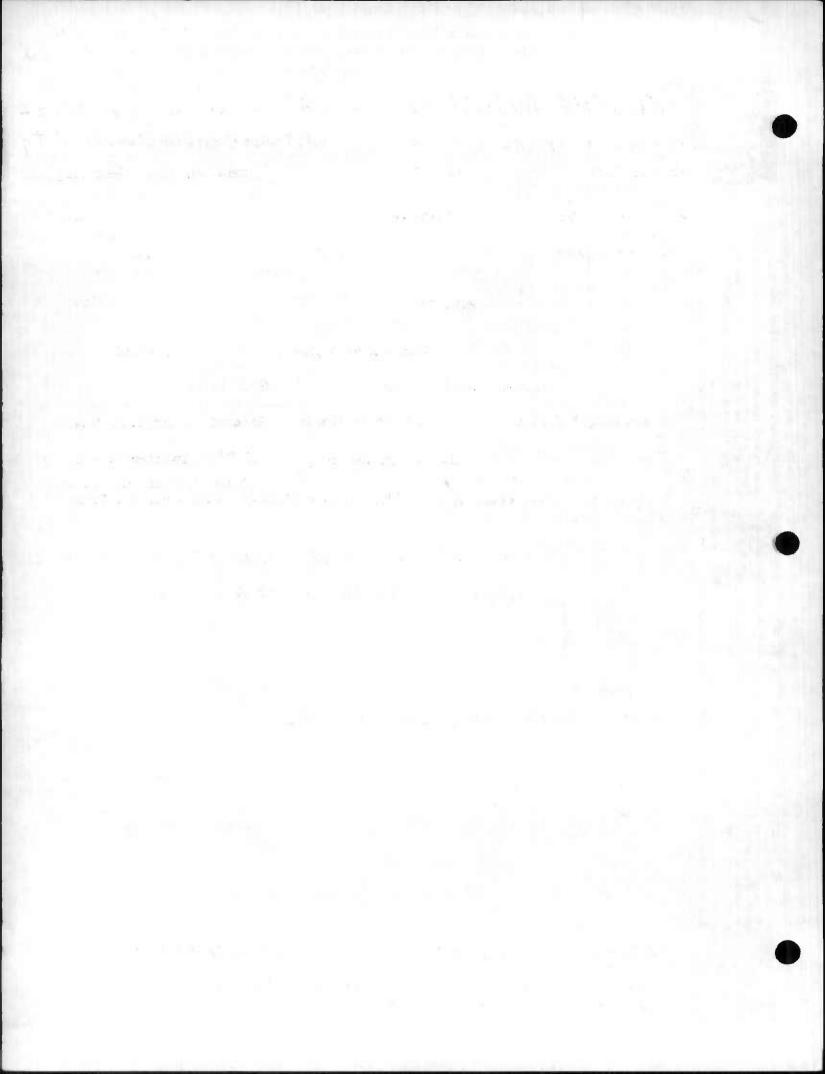


			State of Ma	aryland	d / Departme Certific					3/	30553			
	-	Decedent's Neme (First, Middle, Last)	)		Oertino	ale of L	Jeani	2. Date of Dec	Reg. No.		3. Time of Deeth			
Physic	ian	ELICENE		CTI	NE W	010	HT	Month	Dey	Yeer	3. Time of Deetil			
/Medi		4e. Fecility Neme (If not Institution, give		211/	U			Location of Death	4c. County	97	15:52			
Examir	ner			SUF	20			ORE CIT			05 1.+			
Funeral Director		5. Social Security Number 6. Sec	ITAL CO			der 1 Yeer	if Under 24 Hrs Hours Min	8. Dete of Birt	5	9. Birthp	place (State or Foreigh http) t Virginia			
P.		Usuel Residence of Decedent	,											
e Marylar Sa-f show	ctor	Maryland N/A			Town or Location					1	0d. Inside City Limits 1    Yes 2 □ No			
th with th	Funeral Director	10e. Street end Number 10f. Zip Code 21225							10g. Citizen of V		itry?			
72 hours after death with the Maryland natural, or items 23s or 28s-f show dies Exarriner must be notified at	by Funer	11. Marital Status  1 □ Never Married 2 Married  1 □ Never Married 2 Married  1 □ Was Decedent Armed Forces?  1 □ Yes, Give Year or Detes:		No	If Yes, s	Was Decedent of Hispenic Origin? (Specifit Yes, specify Cuben, Mexican, Puerto Ric     □ Yes 2 No Specify:			cify Yes or No- Rican, etc.)  14. Raca - Bleck, V		American Indien, White, etc.			
C . E	Completed	15. Decedent's Edu (Specify only highest gred Elementery/Secondary (0-12)	cation		16e. Decedent's U (Give kind of life. DO NO	work done d Tuse retired)	uring most of wo	orking	16b. Kind of B					
filed with Hygiene. rther than	Con	12th Locomotive Engine					ineer		Railroad e (First, Middle, Meiden Sumeme)					
Mental Mental arked c	To Be	17. Father's Name (First, Middle, Last) Wi	lliam Cha	arles	Wright			me (First, Middle, leorgia W		ne)				
6 m m		19e. Informent's Neme/Relationship (Ty						ural Route Numbe						
m 27		Louise Wright / w	rire	not Di	600 Arsa		nue E	Baltimore						
호프 등		20e. Method of Disposition 1X Buriel 2 ☐ Cremetion 3 ☐ R	emovel from Stete	Ce	eca of Disposition ( metery, cremetory	or other place		Date	20c. Location					
Trant:		4 ☐ Donetion 5 ☐ Other (Specify)		Ho1	y Cross C		-	10/8/97	Baltim	ore,	Maryland			
permit. Pages and Department of them 27 Important: if item 27 any injury or other to once.		21. Signeture of Funeral Service Licensee Conce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225												
Physician /Medical personned attending physician and attending physician and I for use as the prival-transit	an/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)  Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	. A DVA	NCE Due to (or	MYOCA as e consequence D LUI es e consequenca	of): V G of):			TON	7	Onset end Deeth			
t the death by the atter tached for t	by Physician/M	Part II. Other eignificant conditions con	tributing to death bu	ut not resul	ting in the underlyin	g cause give	n In Pert I.		/		the cause of death?			
an that	y P	CHRONIC OBST	RUCTI	UE	LUNG	DISE	ASE	102	res 2 No	3 Prot	bably 4 ☐ Unknown			
Been	Completed b	DIABETES N	ne LLIT	US					en eutopsy med?	COL	ere eutopsy findings eileble prior to mpletion of cause deeth?			
icion: The income certificate h		HYPERTEN:	SION					1 🗆 Y	es 2 No		Yes 20/No			
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the une	ition: To	27. Menner of Deeth Naturel 5 Pending 2 Accident Investigation				Home 5 Resid			1)					
크 축 불 드	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Pleca of Injury - At home, ferm, street, factory, o building, etc. (Specify)						28f. Location (5 City or Ton		er or Rura	I Route Number,			
To the Hospital within 24 hours a To the Funaral (completely filled	edical	29e. Certifier (Check only one)  12 Certifying Physical Examination (Check only one)	ician: To the best of ear: On the basis of end menner ste	examinetle	ledge, deeth occurr on end/or investiget	ed et the time ion, in my op	e, dete end pleca Inlon, deeth occa	a, end due to the curred et the time, c	cause(s) end me date end place,	enner as st end due to	eted. the ceuse(s)			
within 2 To the	×	29b. Signeture end title of certifier				29c. License	number		29d. Date signe	d (Month, i	Dey, Year)			
, x1		Alter Mass	HOUSE			AS 2	441614	1-60	oct.	4,	1997			
/ / \		30. Neme end eddress of person who co	impleted cause of de	eein (item :	zoa) (Type, Print)									

SOUTH HANDUER STREET

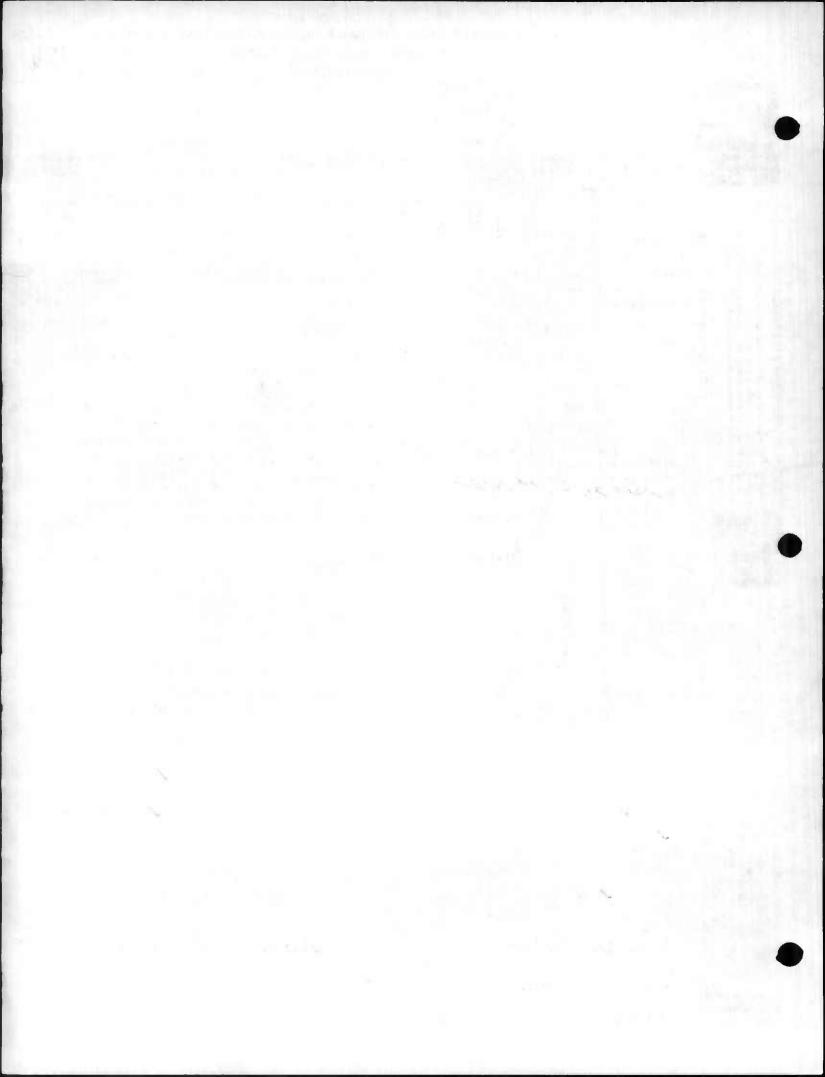
State Registrar ATHIR J. MEROGI 3001 SO

31. Dete filed Month Day Year June Day Year Signetur Random R



State of Maryland / Department of Health and Mental Hygiene 97

					Cer	tificate o	of Death		Reg. No.		00004		
Dhyoici		1. Decedant's Name (First, Middl	o, Last)					2. Date of De		Year	3. Time of Death		
Physici /Medic		Luc	y Ann Wei	SZ				0.0-	6, 199		9:55 AM		
Examir		4e. Facility Name (If not institution	, give street and number	er)			4b. City, Town, or I	ocation of Deat	h 4c. County	of Death			
			ist Cente				Tows				.more		
Funeral Director		5. Social Security Number 217–48–3813  Usual Residence of Decedent	6. Sex 7.	Age (In yrs. 47	last birthday) Yrs.	Months Day		8. Date of Bir (Month, Da AUG 11	th iy, Year) 1950	9. Birthple Count Wash:	ace (State or Foreign try) ington, DC		
the Maryland 28a-f show	tor	10a. State 10b. County MD N/A			y, Town or Local Baltim					10	Od. Inside City Limits		
3a or 28s	Funeral Director	10e. Street and Number 10f. Zip Code 5719 Oakshire Road 21209							10g. Citizen of USA	What Count	ry?		
ire, Maryland Z1Z15-00Z0 and 2 should be filed within 72 hours after deeth with the Maryland theath end Mental hygiene. that 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exercise ment be notified as	by	11. Marital Status  1 Never Merried 2 Marr 3 Widowed 4 Divorced	12. Was Decede	s? X No	\$f		of Hispenic Origin? (Suban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Rac Bla	ca - America ck, White, e y: Whi	etc.		
Z1Z15-00Z0 d within 72 hours af giene. rr than "natural", or r. the Wed cal Exam	Completed	15. Deceden (Specify only higher Elamantary/Secondary (0-12)	15. Decedent's Education lify only highest grade completed) ndary (0-12)  Collage (1-4or		16a. Decede (Give k life. D	16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)  Attorney		f working MD		Kind of Business/Industry  D State  overnment			
filled with Hygiene ther thai	Co		5+	5+									
be fill H d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam			ne)			
should be and Mental marked o	2							ta Fab					
d 2 should be file th end Mental Hy 7 is marked oth traumatic event		19a. Informant's Name/Relations					eet and Number or Ru				Code)		
		David F. Weisz/  20e. Method of Disposition  1 □ Burial 2 ②Cremation  4 □ Donation 5 □ Other (S)	3 □Removal from Sta		lace of Dispos emetery, crem	ition (Name of atory or other p	burn Dr. F	Dete	20c. Location -	City or Tov			
parmit. Page Decarment of Important: If any injury or once.		21. Signeture of Funeral Service		I He	Ĉr.	Name and Add	dress of Facility  Society	of Mary	Baltimo land, Ir	nc.	וט		
402/40		George E. Ma	cNabb		29	9 Frede	erick Rd.	Baltimon	re, MD 2	21228			
Physician /Medical Examiner	iner	shock, or heart failure. List Immediate Cause (Finel disease or condition rasulting in death)	a. Meth	static	r as a consequ	(qnumq ance of):					Interval Batween Onset end Death  Z ~eq r S		
	/Medical Examiner	Sequentially list conditions, if any, leading to Immediate causa. Enter Underlying Cause (Disasas or Injury that initiated evants resulting in daath) Last	c		r as a consaqu	V-2-1							
eath ce attend for us	cian	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobecco use contribute to the cause of death?					
ediby th	y Physician	Part II. Other significant conditio	ns contributing to death	but not resu	ulting in the und	lerlying cause	given in Part I.		tobecco use co Yes 2 No		the cause of death? ably 4 🗆 Unknown		
or Attending Physician: The lay requires after death.  Director: After this certificate has been for in by the funeral director, page 2 should be	Completed by							perfo	en eutopsy ormed?	avai	ra eutopsy findings ilable prior to apletion of cause eath?		
iclan: The li certificate ha								10'	Yes 2 No	1 🗆	Yes 2□ No		
Physician: this certific	Be	25. Was casa referred to medical examiner?	Hospitel:				26. Placa of Dea		1				
After this funeral di	ion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pandin	28a. Date of In		ER/Outpatient 28b. Tima of Injury	28c. In	jury at Vork?		dence 6 Oth how Injury occur		HOSPICE		
tal or Attending P rs after death. al Director: After ed in by the funers	Certification:	2 Accident invastig 3 Suicide 6 Could r 4 Homicida determi	ot be		☐ Yes 2☐ No	28f. Location (Street and Number or Rural Routa Number, City or Town, State)			Routa Number,				
	edical	29a. Cartifier 1 Certifying (Check only one) 1 Madical E	Phyaician: To the bas examiner: On the basis and manner:	of examinat	wledga, daath o ion and/or Inve	occurrad at the stigation, in my	tima, data and placa, y opinion, daath occur	and due to the red at the time,	causa(s) and me date and place,	enner as sta and dua to t	ited. the causa(s)		
To trota	M	29b. Signature end title of certifier	Sh-				D38409		29d. Data signe		ay, Year)		
Sta	te	30. Nama and address of person of the state	Ae	Buth.	re (		122 ( Willi	lam H. S	harfman	, M.D	•		



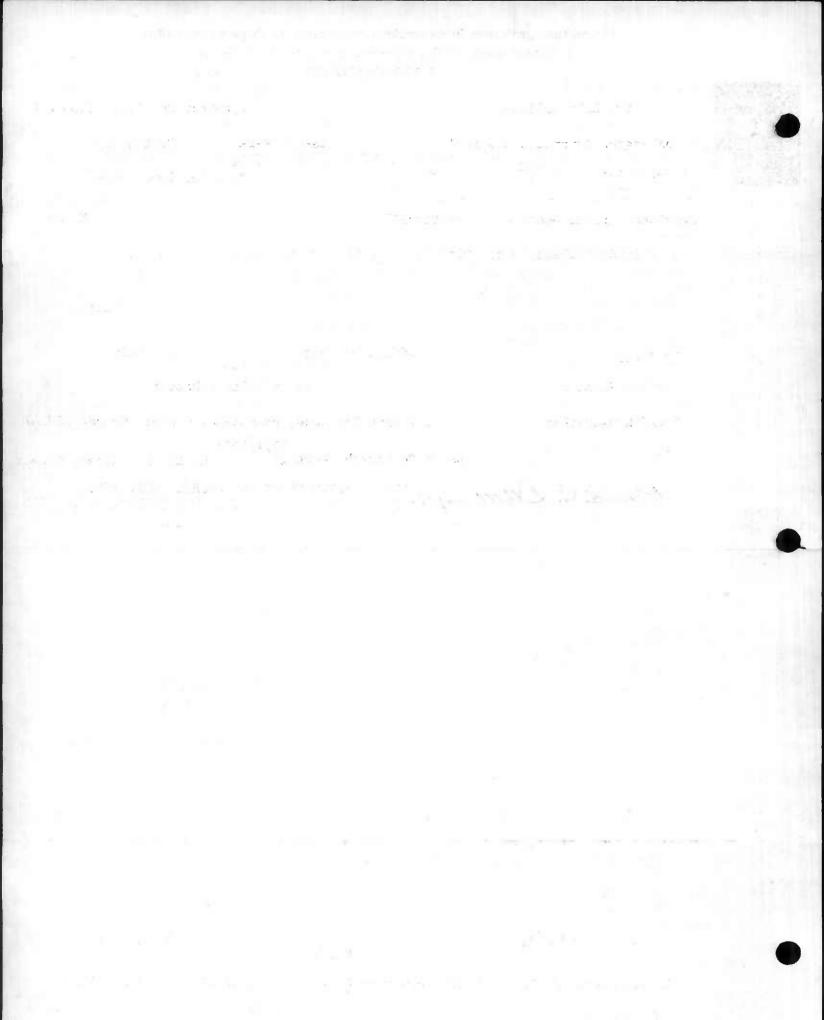
State of Maryland / Department of Health and Mental Hygiene

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					Cer	tificate of	Death		Reg. No.		0000	
4.1.1		1. Decedent's Neme (First, Middle, La	st)					2. Dete of D		Maria	3. Time of Deep	th
Physicia		Eve Lily W	illman					Septem	ber 30,	Yeer 1997	3:50 A	М.
/Medic Examin	_	4e. Facility Neme (If not institution, giv					4b. City, Town, or				3134 11	
LXamin	٠.	Washington Adven	tiet Hoenit	- 1			Takoma P	ark	Mont	omer	ur.	
Francial I		5. Social Security Number 6. S		in yrs. last b	irthdev)	If Under 1 Year				4-	4	reinn
Funeral Director			□M XXF	89	Yrs.	Months Deys	Hours Min			-	lece (State or For	olg//
natural, or items 23a or 28a-f show Sical Examiner must be notified at	1	Usuel Residence of Decedent		09				June	13, 1908	Can	ada	
N 111		10e. Stete 10b. County 10c. City, Town or Location								10	Od. Inside City Lir	mits
r than "natural", or flems 23s of 26s-1 show the Medical Examiner must be notified at	ō	Maryland Prince G	eorges	Hyatt	svi1	1e					Y⊠ Yes 2□	No.
nout	Directo	10e. Street end Number	001800	ny acc	0 1 1 1	10f. Zip Code	:		10g. Citizen of	What Coun	lov?	
2			at Ant 50	1.1							, , , ,	
2	Funeral	630 Sheridan Stre			40.10	20783	10.110.1		U.S.			
	5	11. Meritei Stelus	12. Wes Decedent Eve Armed Forces?	er in U,S.	13. V	ves Decedent of Yes, specify Cut	Hispenic Origin? (S pan, Mexican, Pue	Specify Yes or N rto Rican, etc.)	Bie	ck, White, e		
	by F	1 Never Merried 2 Married	1 ☐ Yes 2 🔯 No If Yes, Give		1	☐ Yes 2 No	Specify:		Specifi	y:		
		3 N Widowed 4 □ Divorced	Year or Detes:			21,				Whi		
	ete	15. Decedent's Ed (Specify only highest gra		16	B. Decedi (Give I	ent's Usuel Occu kind of work done	petion during most of wa	orking	16b. Kind of B	usiness/Ind	ustry	
1	Completed	Elementery/Secondery (0-12)	College (1-4or 5+)			O NOT use retire	•					
	S	12 Years			Off	ice Mana			Accou			
	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Ne	me (First, Middl	e, Meiden Sumen	1e)		
	2	Abraham Neamtan					Esther	Malca S	chacter			
		19e. fnforment's Neme/Reletionship (	Type, Print)	19	b. Meilin	g Address (Stree	t end Number or R	lural Route Num	ber, City or Town,	Stete, Zip	Code)	
		David Housefathe	r	2	07 F	inchley	Road, Ha	mpstead	, Quebec	, Can	ada H3X	3A7
		20e. Method of Disposition		20b. Plece	of Dispos	sition (Neme of netory or other pla	2001 10	Dele	20c. Location	City or To	wn, State	
5		1XDBurlel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specifi					Cemetery	1/1997	1		1	. 1
1	1	21. Signeture of Funerei Service Licer		Dalon	-	Name end Addr			Montreal	, que	bec, Car	naa
any injury or once.			^		CT	ETM HEDE	DELL MEMOD	TAL FUN	ERAL HOM	E. TN	C	
		23a. Part1. Enter the disease, or com shock, or heart feilure. List only	Stottle	nye	2 23	2_CARROI	L STREET	N.W.	WASHING	TON.	D.C. 200	012
		23a. Part1. Enter the disease, or com- shock, or heart feilure. List only	plications that caused the one cause on each line.	e on. Do	not ente	r the mode of dy	ing, such es cardie	oc or respiretory	arrest,		Approximeta Interval Between	1
ian										3	Onset end Deeth	h
cal ner		Immediate Cause (Final disease or condition	·INTRAC	RAN	VAI	BLE	EDMA	9		76		
er		resulting in deeth)		e to (or es e								_
-	ne.									1		
	Examine	Sequentially list conditions.	b. Du	e to (or es e	consequ	uenca of):						
		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying								į		
	edical	Cause (Diseese or Injury Thei Initiated events	C. Du	e lo (or es e	consequ	ience of):				-		
	8	resulting In deeth) Lest				,				i		
	2		d						· · · · ·	<u> </u>		
	Physician	Pert II. Other aignificant conditions or	antellection to don't but a	ot requiting	Im the same	dark dan sawaa a	han in Bart I	22h Du	d tabana una nan	mtulbusta ta	the seven of de	anth O
	YS	reit ii. Other arginitican conditions c	ontributing to death but i	iot resulting	in the un	denying cause g	iven in Pen I.		i tobacco use co			
								1	Yes 2 No	3 ☐ Prob	ably 4 Unkr	nown
3	D D							040 1840		24h Wa	re autopsy findin	none.
	ete							per per	s en eutopsy formed?	eva	lieble prior to	
7 5	Completed										leath?	
1	0							1□	Yes 2000	1 🗆	Yes 2 No	
	Be	25. Was case referred to medical					26. Plece of De	eth (Check only	one)	-la-		_
	0	exeminer?	Hospitel:	2 ER/C	utpetient	3 DOA	her: 4 Nursing	Home 5 Res	sidence 6 Oth	ner (Specify	·)	
		27. Menner of Deeth	28e. Dete of Injury		Time of	28c. inju		1	how injury occur			
	9	XX Neturel 5 Pending 2 Accident Investigation	(Month, Day Y	ear)	Injury		Yes 2□No					
,	100	3 Suicide 6 Could not be	28e. Place of Injury	- At home, f	arm, stre	el, fectory, offica	1	28f. Location	(Street end Numb	per or Rura	Route Number,	
	Certification:	4 Homicide	building, etc. (	Specify)	,	,		City or To	own, Stete)			
		29e. Certifier tXXCertifying Ph	veleing. To the heat of a	na ka awala da	a danth	accurred at the L	ima data and sina	n and due to the			atad	_
	edical	(Check only one) 2 Medicel Exam	ystcian: To the best of n niner: On the basis of ex	eminetion e	nd/or inv	estigetion, In my	ime, dete end piec opinion, deeth occ	e, and due to the urred et the time	e cause(s) and me , dete end placa,	and due to	the ceuse(s)	
		29b. Signeture end title et certifier	end menner steted	3.		20a Lloon	se number	· · · · · · · · · · · · · · · · · · ·	29d. Dete signe	d Month	Day Vosel	-
		290. Signature end title at pertiner	M			29C. Licen	se number		_			
		P . ON	4 000			D2 5	977		1.3	0-5%	/	
11		30. Neme end eddress of person who	completed cause of deet	h (Item 23a)	(Type, F							
U		A. Dashottar, M	. D. 72	07 Ha	nove	r Parkwa	ay, # A,	Greenbe	lt, Mary	1and	20770	
Stat	е	31. Dete filed (Month, Dey, Year)	32. Registrer's	Signeture					-			
gistra	r	OCT 0 81997	Julia Wavida	m-Rang	fello.							
		441 41441	()	-	1.100							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30556 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Yasinskil 5:38PM October 199 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Sinai Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Month, Day, Y

JUN 16, 1 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**X**M 2□ F 36 Yrs. Director N/A Germany Usual Residence of Decedent 10a. Stete N/A 10b. County N/A death with the Meryland permit. Peges 1 and 2 should be filed within 72 hours after death with the Manylar Department of Health end Mentel Hygiene. Important if them 27 is marked other than "natural", or items 23e or 28e-1 show eny infury or other traumatic event, the Medical Example in this ball included and other. 10c. City, Town or Location 10d. Inside City Limits Country 1 XYes 2 No Director Kirishi Russia St. Petersburg Region 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 40 Lenin Street, Flat #43 N/A Completed by Funeral Russia 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 XNo Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) 5+ Engineer Aeronautical Design Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Nikolas Yasinskiy P Maria Perfileva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valeriy N. Yasinskiy / brother 80 Nikitin, Flat#16 Tver, Tver Region, Russia 20b. Place of Disposition (Name of cemetery, crematory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/08/97 Baltimore, MD 21. Signature of Fuseral Servica Licensae 22. Name end Address of Facility
Cremation Society of Md., Inc. 299 Frederick Road Baltimore, MD 21228 George E. MacNabb 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart feilura. List only one ceuse on aech line. Approximata Intarval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical Metastatic Malianant Sarcoma YEARS Examiner Due to (or es e consequance of): Examiner Attending Physician: The law requires that the death certificate be executed the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in death) Last Dua to (or as e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequenca of): for use es Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ete has been signed by page 2 should be detac 1 Tee 2 No 3 Probably 4 Unknown yision of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? 1 ☐ Yes 2 XNo certificate 1 Yes director, 25. Was case referred to medical examinar?
1 ☐ Yes 2 No Be 28. Place of Death (Check only one) Hospital: 1 Mnpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Rasidance 6 ☐ Other (Specify) 10 this the funeral Medical Certification: 27. Mangar of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Matural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 ☐ Sulcida 6 Could not be datamined 28a. Placa of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 스 N 29d. Dete signed (Month, Day, Year) uller. MD AS 2402321 TM 9018 October 7 1997

State Registrar

31. Date filed (Month, Day, Year) OCT 0 8 1997

West

2401

Belvedere Avenue Baltimore Maryland

30. Nema end eddress of person who complated cause of death (Item 23a) (Type, Print)

the first of the second

ML State of Maryland / Department of Health and Mental Hygiene ARTHUR ANDERSON Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Thur OCTOBER 04 1997 6:42 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARYLAND GENERAL HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 10M 2DF Days 54 Yrs. 217-38-5760 Usual Residence of Decedent **Director** MARYLAND 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Llmits 28a-f show Ma 1 Yes 2 No BALTIMORE 10e. Street and Number 10g. Citizen of What Country? ŏ 1609 NorTh BOURNE 4 5 A

14. Raca - American Indian,
Black, White, etc. Items 23e 21239 Rd. death Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ò 1 Yes 2 No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed traumatic event, The Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Haalth end Mental Hygiena. Important: If Item 27 is marked other than "ne any Injury or other traumatic event, Ita Mada. 2008. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) BRENER TION Baktimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROSACEÉ Anderson 19a. Informant's Name/Relationship (Type, Print) MARY ANDERSON 20b. Place of Disposition (Neme of cemetery, cremetory or other place)

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

20c. Location - City or Town, State 20a. Method of Disposition 1 Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OSCHELL CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Ficility
1639 N. BROAD WA HOMELSERVICE JEFFMILLER P.C. FYNERAL Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final odlfrote cardinasc disease or condition resulting In death) **Examiner** Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last and Due to (or as a consequence of) 68760 Physician/Medical Due to (or as e consequence of) Box Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown ď 1 ☐ Yes 2 ☐ No signed to Records, 29 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? paga 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: The safter death.

Is after death.

In Director: After this certificated in by the funeral director, page. Be 25. Was case referred to medical 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1XYes 2 No Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homtcide To the Hospital of within 24 hours a To the Funeral D filled 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 04 1997 O.C.M.E.

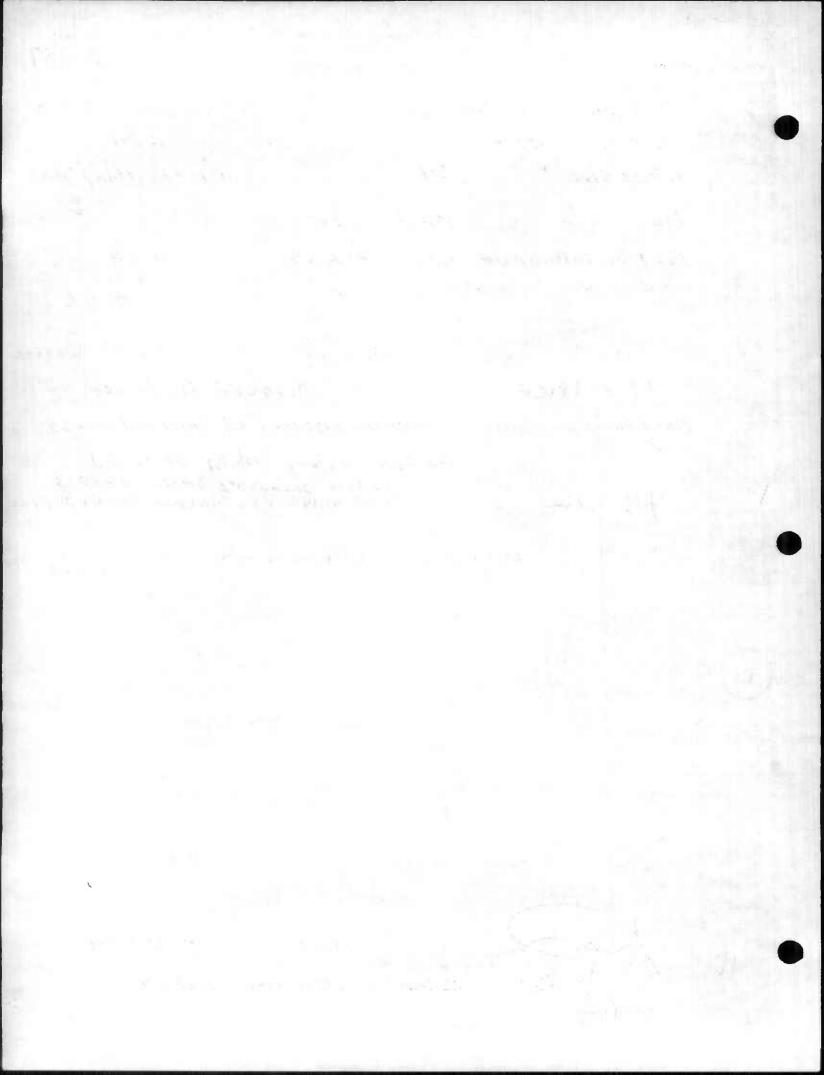
State Registrar

31. Dete filed (Month) Day 9 1997

32. Registrar's Signature full Tavidson Randage

111 Penn Street, Baltimore, Maryland 21201

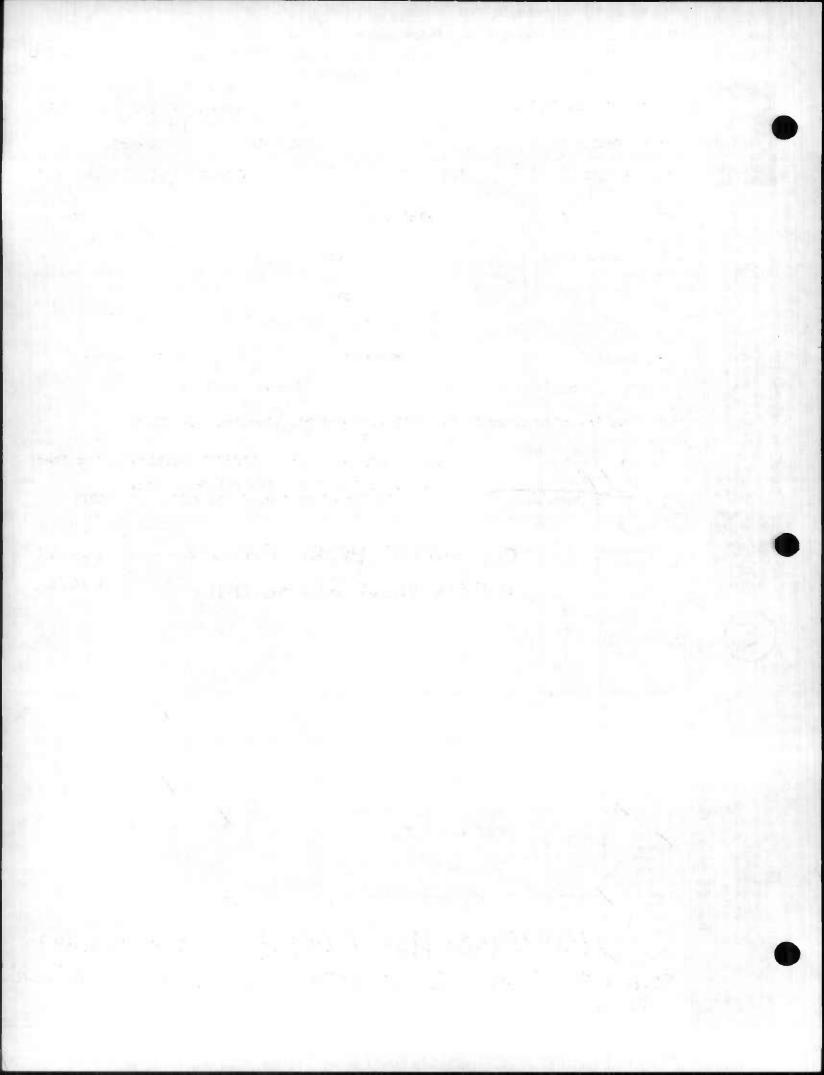
30. Namy and address of person who completed cause of deeth (Item 23a) (Type, Print)



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

					(	Certifica	ate of	Death		Re	g. No.			
sician	1. Decedent's Nar	ne (First, Middle, L	ast)						2	Date of Death	-	Year	3. Tim	e of Death
cian lical	Stella	M. Brand	lenburg						C	ctober	6, 199	97	4:0	05 PM
iner	4a. Facility Name	(If not institution, g	ive street end numbe	er)				4b. City, Town	n, or Local	tion of Death	4c. County	of Death		
		Senior Ho	ome					Colum				ard		
il ir	5. Social Security  212-03  Usuel Residence	-7115	Sex 7 1 □ M 2 1 F	Age (In yrs. 102	last birtho	Month	der 1 Year ns Deys		Min.	Date of Birth (Month, Day, anuary	<sup>Year)</sup> 22,18	9. Birthp Coun 95 Wa	place (Stanty) sh.,	D.C.
	10a. State	10b. County		10c. Ci	ty, Town o	or Location						1	0d. Insid	e City Limits
0	MD	N/A		1	Balti	more				1 🔯 Yes				
rec	10e. Street and No	umber				10f.	Zip Code			10	g. Citizen of \	What Cour	ntrv?	
Funeral Director		rose Ave	-				2122				U.S.A.			
þ		rled 2 Married	12. Was Deceder Armed Force 1  Yes 2  If Yes, Give Year or Date:	s? XNo	,S.	if Yes, s	pecify Cul	Hispanic Orlgir pan, Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or No- ean, etc.)		ce - Americ ck, White, y: Whi	etc.	١,
etec	(Spe	15. Decedent's E	Education rade completed)		16a. D	ecedent's U	sual Occu	pation during most o	f working	1	6b. Kind of B		-	
Completed	Elementary/Sec	-	College (1-4c	or 5+)	- li	fe. DO NOT	use retin	9d)						
	6th Gr	ade (First, Middle, Las	#1		H	ousewi	fe	10 14-1-1	Nem	Time satural t	Her or		me	
Be			,							First, Middle, M	_	10)		
2		W. Adams			1	A 100 C 1				Irelan	-			
	19a. Informant's Name/Relationship (Type, Print)  Mary Hutchinson/Daughter-in-Law  2402 Burlwood Rd. Timoniu											Code)		
any injury or other traumatic once.	20a. Method of Dis		baugirter-			isposition (f		ra. T			0c. Location -		Ctat	
	N Burial 2	•	□Removal from Star ify)	te	cemetery,	Park	r other pla		1		Baltimo			
OUCE.	21. Signature of F	unifal Solvice Life	ensee MA					ess of Facility Ashton Ison Av					L228	
	23a Partt. Enter shock, or he	the disease, or cor art feilure. List only	nplications that caus y one ceuse on each	ed the deat line.	th. Do not	t enter the m	ode of dy	ing, such as ca	rdiac or r	espiratory arre	st,		Approxi Intervel Onset e	mete Between nd Deeth
al er	Immediate Cause disease or conditi resulting in death)	on	a. CUN					RT 1	PAI	LURE			3418	ARS
ē			W)	TRA	or as a co	Con 116		EGURI	, +	MILTOR	)		SYE	ARS
Examiner	Sequentially list of if any, leading to licause. Enter Und Cause (Disease o	onditions, mmediate erlying	b. 1166			nsequence o		CUN	١١٠	b II U		1		13
Medicai	resulting in death) Last  Due to (or as a consequence of):													
clan			u								_	1		
sic	Part II. Other signi	ficant conditions	contributing to death	but not res	ulting in th	ne underlyin	g cause g	iven in Part I.		23b. Dld tol	pacco use co	ntribute to	the cau	se of death?
by Physi										1 🗆 Ye	2 2 No	3 □ Prol	bably	I □ Unknown
Completed										24a. Was ar perform		av.	ailable pr	esy findings for to of cause
Con										1 ☐ Ye	s 2/1 No	10	Yes	21/2 No
Be	25. Was case refe exeminer?	rred to medical						26. Piece of	f Death (0	Check only one	)			/
To	1 ☐ Yes 22	No	Hospital:		ER/Outp	atient 3	DUA	ther: 4 🗆 Nursi	ing Home	5 Reside	nce 6 Oth	er (Specif	y)	
	27. Manner of Dee 1 ☑ Naturel 2 ☐ Accident	th 5 Pending Investigation	28a. Dete of Ir (Month, L	njury Day Year)	28b. Tim Inju		28c. Inju	ork? Yes 2 □ No		d. Describe ho	w Injury occur	red		
Certification:	3 ☐ Sulcide 4 ☐ Homlcide	6 Could not determined	200. Place of	Injury - At h etc. (Specif	ome, farm	, street, fact	ory, office		28f	Location (Str City or Town,	eet and Numb State)	per or Rura	i Route t	vum <i>ber</i> ,
edical	29a. Certifier (Check only one)	1 Certifying P	hyaiclan: To the bes miner: On the basis and manner	of examina	wledge, d	leath occurre or Investigati	ed at the ton, in my	ime, date and p opinion, death	piace, and occurred	due to the ca at the time, da	use(s) end me te and place,	enner es si and due to	teted. the cau	se(s)
Me	29b. Signature	title of certifies	1.		1.4		29c Licen	se number			d. Date signe			
	1	all	Naw	101	NV	0	1)2	990	19					797 Dzwy
	SCUM	may (	completed sause of	death (Iter	0) (Ty	PPO, Print)	NY	Hous	R	O EL	LICUT	Tur	Y M	D2W4
State	31. Date ( act / pr	0 97997	22. Regis	strar's Signa	ature									

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

30559 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death BLANCHARD Month **Physician** TATE FLORENCE AM 10 97 /Medicai 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FAIRVIEW 3820 AVE Balt, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, **Funerai** 152M 20 F Deys Hours Min 128048 Marca 218 Yrs. Director 30 12 Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10e. Stete 10c. City, Town or Location 10b County 10d. inside City Limits permit, Pages 1 and 2 should be filed within 72 hours efter death with the Manylan Department of Hatilh and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tra Menical Entrine mail to notified an baltimore 1 Yes 2 No Director 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? W. S.A. 3820 Funeral 12W 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No It Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 14. Raca - American Indlen. Bleck, White, etc. 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify Suck by 3 ☐ Widowed 4 ☐ Divorcad Be Completed 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) WS: 2055 Owner Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) woll. 2 19e. Intormant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 3820 FA; RV; EW Ave, Balk W3

20b. Pleca of Disposition (Name of cemetery, cremetory or other plece)

Dete 20c. Local SN 1446HM 20e. Method of Disposition Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel trom State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Juperal Service Licensee Irvist 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart tellure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediete Ceuse (Finel disease or condition resulting in death) CEREBRAL THROMBOSIS /Medical MO. Examiner Due to (or es e consequenca ot): Physician/Medical Examiner HYPERTENSION 80 The law requires that the death certificate be executed for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): and MELLITUS DIABETES TL P.O. Box 68760. physician Due to (or es e consequenca of): POLYNEUROPATHY Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? director, page 2 should be detached DEMENTIA 6 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were sutopsy tindings aveileble prior to completion of cause of deeth? Completed 24e. Wes an autopsy peen performed'i certificate has 1 Yes 2 DNo 1 ☐ Yes 2 ☐ No Division of Vital m or Attending Physicien: The ster deeth.

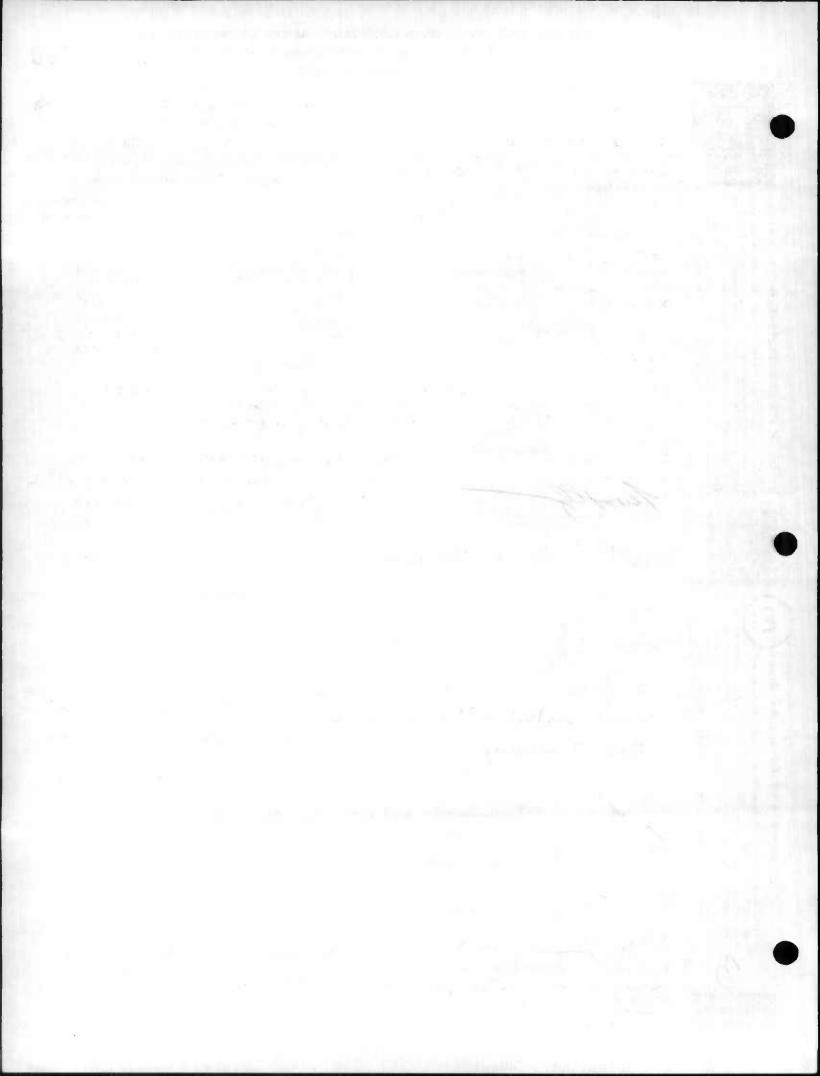
In Director: After this certificate in by the funeral director, pe 25. Wes case reterred to medical exerciner?
1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menger ot Deeth 28e. Date of injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Maturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, ferm, street, tectory, offica building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours Furnital 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner steted. 29e. Certifier edical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d, Dete signed (Month, Dav. Year) 016306 97 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) BROADWAY BALTIMORE 21231 98 4. Figistry's Signeture Randelle 31. Date tiled (Month, Day, Year) OCT 0 9 1997 State Registrar

State of Maryland / Department of Health and Mental Hygiene 97

30560 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middia, Last) 3. Time of Deeth October **Physician** Alfonso Brice 12:13pm /Medical 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 2925 Sylvan Avenue Baltimore 5. Sociel Security Number If Under 1 Yaar if Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Funerai Birthplece (Stata or Foreign Country) 1 □ M 2 □ F Months Days Hours Min 229-14-1505 78 Yrs. Director 09-22-19 VA Usuel Rasidence of Decedent 10a. State 10b Counts 10c. City. Town or Location 10d. Inside City Limits Md NA Baltimore Director XI Ves 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 2925 Sylvan Avenue 21214 Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 24☐ No If Yas, Give Yeer or Detes: 14. Reca - Amarican Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puarto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ XNo Specify: Completed by Specify: Black 3₺ Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Baltimore City Dept Elemantary/Secondery (0-12) Coilega (1-4or 5+) Rec. & Parks Laborer 6thGrade 7 is marked other traumatic event, I permit Pages I and 2 should be file Department of Hoalth and Mentel Hy important: If New 27 is marked other any Injury or other traumatic event. 17. Fether's Neme (First Middle Last) 18. Mother's Name (First, Middla, Maiden Surname) Be Brice Alfred Daisy Brice 19a. informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 21214 Frances M. Smith 2925 Sylvan Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete N☐ Buriel 2 ☐ Cremation 3 ☐ Ramoval from State 10-09-97 Randallstown, Md. King Mem. Pk. Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funerei Service Licensee 22. Nama and Addrass of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Onsat and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medicai Bladder Two years **Examiner** Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to immediate causa. Entar Undarlying Cause (Disease or Injury that Initiated avants rasulting in deeth) Lest Due to (or es a consequenca of): Due to (or es e consequence of): P.O. Box Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Chronic Obstructive Pulmonary Orsense 1 ☐ Yes 2 ☐ No Records, 24b. Wera autopsy findings evailable prior to completion of causa of death? Completed 24e. Was en eutopsy performed? Renal Insufficiency 1 ☐ Yes 2 ☐ No 1 Yas 2 No Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

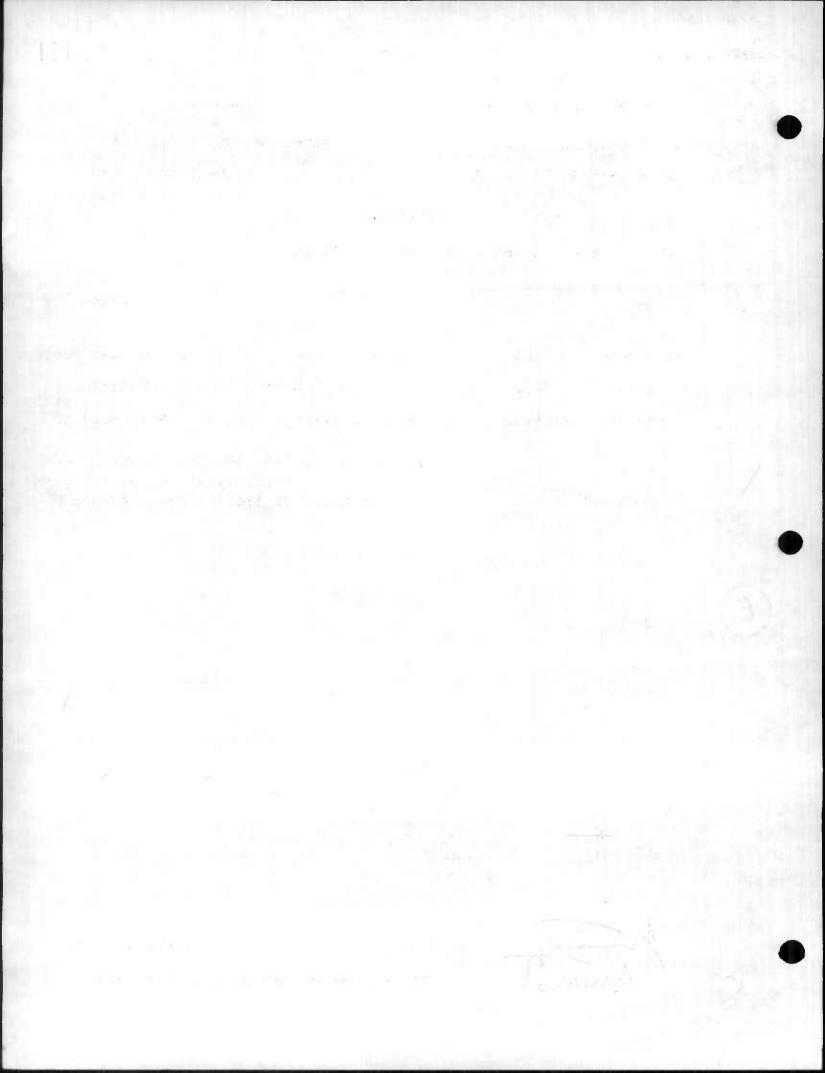
To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred in medical 26. Piece of Deeth (Check only Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Deta of injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred et tha time, date end pleca, end due to tha ceusa(s) and mannar as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daath occurred et the time, date end pleca, and due to the causa(s) and menner steted. 29a. Certifier 29b. Signature end titla of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) RES-UDU October 30. Neme end address of parson who complated cause of deeth (item 23e) (Type, Print) 110 Tower, Johns Hupkins Hospital, Baltimore, Murgland
32. Registrer's Signeture 31. Date filed (Month, Day, Year) State Lika Tavidson-Randoll Registrar GCT 0 9 1997 DHMH 16 Rev 6/95



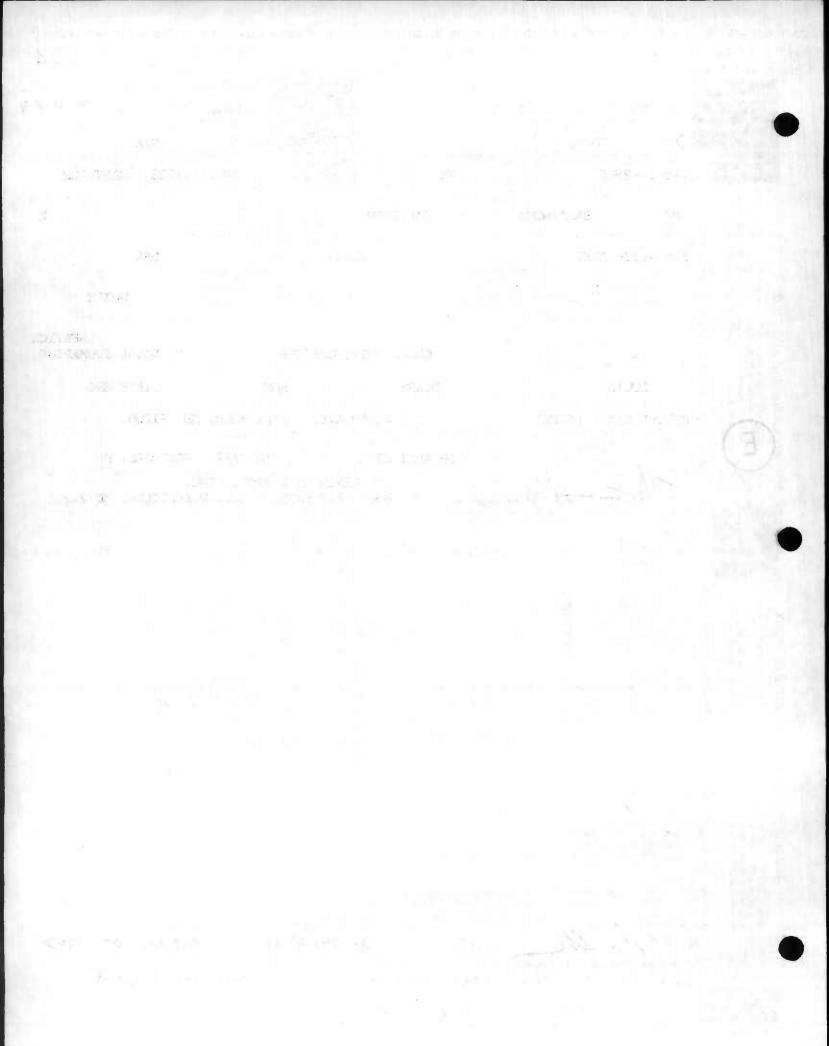
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aminer	4	4a. Facility Name (/	If not institution, giv	e street and numbe	9r)			4b. City, Town,	or Location of Dea	th 4c. Coun	ty of Death		
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any injury or other tr	-			Removal from Stat	(e	e of Disposition (/ etery, crematory o			Date				
	21. Signature of Funeral Servica Licansea  22. Name and Address of Facility  Baltimore, Maryla										rylan	d 21202	
	+	WM.C.March FH 1101 E. North Avenue  23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate											
ner		Immediate Cause ( disease or condition resulting In death)	Finel		OTIC, COO	CAINE AND A	LCOHO!					Interval Between	
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State of Maryland / Department of Health and Mental Hygiene 97 30562

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Physician /Medical	_	Kopel Sidney	E	Biars							October	07	199		8:30 A	4
Examiner	-	4e. Facility Name (If not institution,		end number)						own, or Lo	cation of Death	4c.	County of D	eeth		
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Funeral	т	5. Societ Security Number	6. Sex 1)2 M 2		(In yrs. las	st birthdey Yrs.	) If Under Months			Min.	(Month, Day		9.1		e (Stete or Forei	gn
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		18 1 L	(	N	ID		A	52	4023	321		Octo	ber	07	1997	
	3	30. Neme and eddress of person w	ho complet		eth (item 2	3a) (Type	, Print)									
U		Erik DeLue	240	91 w	est	Bel.	reder	e	Avenu	e	Baltim	ore	Mary	land	1997	
State		31. Dete tiled (Month, Day, Year)		32. Registre	rs Signatui	10				7	-				Versilities	
Registrar		OCT 0 9 19	97	guia	Davids	on-Ra	della									



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30563 Certificate of Death 1. Decadant's Nema (First, Middla, Last) 2. Dete of Death Month **Physician** /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea **Examiner** 2150 RU BAltimor YAC 5. Social Security Number 217-26-4314 Usual Rasidance of Dacedant 7. Aga (In yrs. last birthday) 5 Yrs. If Undar 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days M 2DF Director 10a State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Completed by Funeral Director 10f. Zip Coda 10g, Citizan of What Country ŏ Items 23a 12. Was Decedent Ever In U,S. Armed Forcas? 1 □ Yes 2 □ No 5/-13. Was Decedant of Hispenic Origin? (Spacify Yas or No If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 11. Maritel Status Rece - American Indian, Black, White, atc. permit. Peges 1 and 2 should be filed within 72 hours efter of Department-of Heelth and Mental Hygiene. Important: If them 27 is marked other than "natural", or then any Injury or other traumatic event. It 1 Nevar Married 2 Married Giva Por Datas: 21215-0020 1 🗆 Yas 2 DNO 3 □ Widowed 4 □ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work done during lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15 Decadent's Education Elamantary/Secondary (0-12) Collage (1-4or 5+) 10 Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) Be 20a. Mathod of Disposition Placa of Disposition (Na cemetery, crametory or Burial 2 Crametion 3 Removal from Stata 5 Othar (Specify) 21. Signeture of Funeral 5 Approximate Intarval Batween Onset and Death Part : Enter tha disaesa, or complications that causad tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Physician /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed use as the buriel-transit Sequantially list conditions, if any, laading to Immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Records, P.O. Box 68760. ettending physician Dua to (or as a consaquanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires that th within 24 hours efter death. To the Funeral Director: After this certificate hes been signed by completely filled in by the funeral director, page 2 should be detact 3 Probably 4 Nunknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Wera autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 2 No 1 🗆 Yas 1 ☐ Yas 2 ☐ No of Vital 25. Was casa rafarred to medical axaminar? 28. Placa of Death (Check only ona Othar: 4 Nursing Homa 5 B Idance Medical Certification: To 1 Yes 200 N 1 Inpatiant 2 ER/Outpatient 3 DOA 6 ☐Othar (Specify) 27. Mannar of Daath 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Division 5 Panding Invastigation 1 [] Natural 1 Yas 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straet, factory, offica building, atc. (Spacify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the causa(s) and mannar as stated. 2 Medicat Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end mannar stated. 29a. Certifier

State Registrar

31. Data filed (Mo)

(Check only one) 29b. Signature and

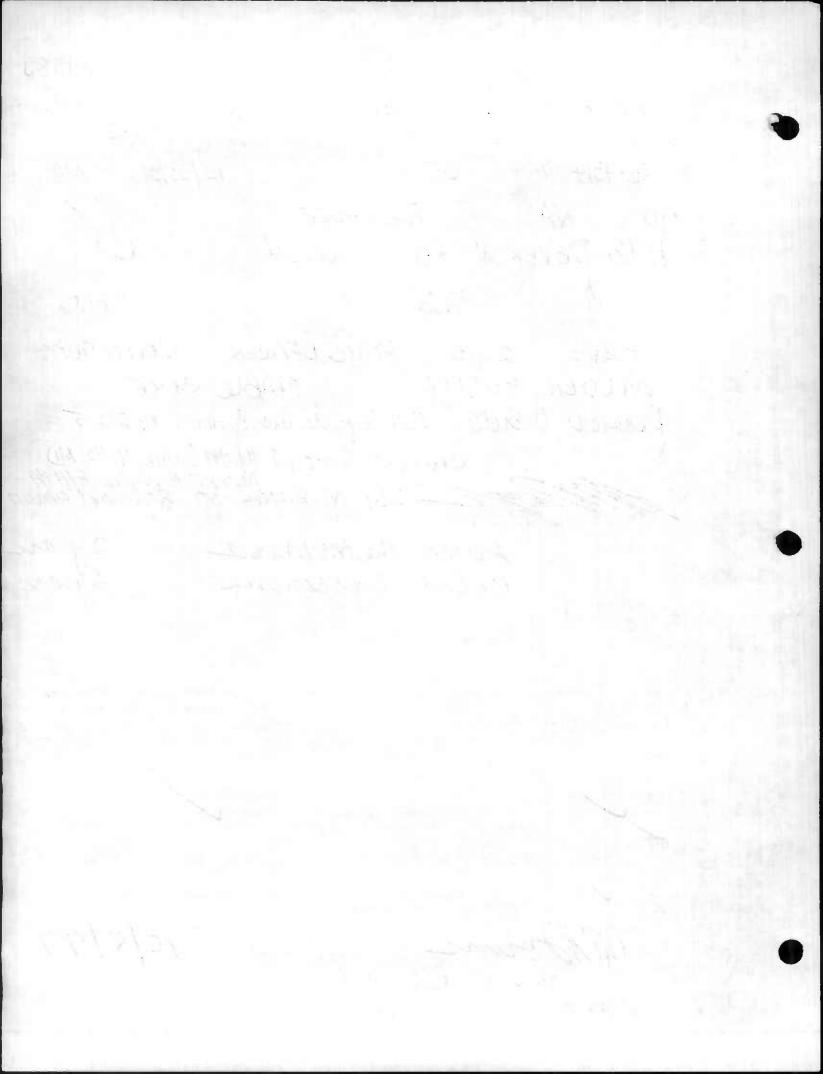
30. Name and ad

ou 32. Registrar's Signatura

(Type, Print)

29c. License number

29d. Data signed Month, Day, Year

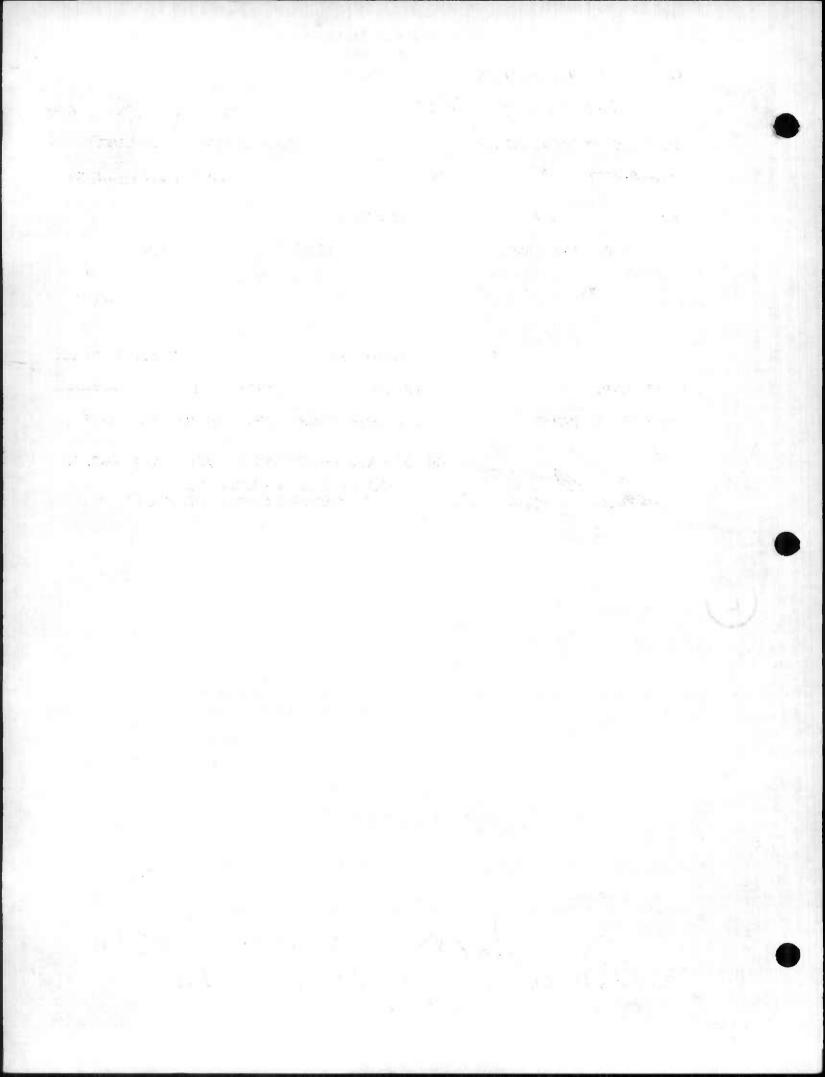


State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: 18 per FH G-752 10-9-97 eoh Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Dey **Physician** 64120 4a. Facility Nama (If not institution, give street and number OCT. 6 1997 5 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner RANDALLSTOWN NORTHWEST HOSPITAL CENTER BALTIMORE If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 8. Sax 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months 1X M 2□ F Yrs Director JULY 22, 217-58-9363 69 1928 LIBYA Usual Residence of Decedant death with the Merylend 10a. Stata 10b. County 10c. City, Town or Location ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 10d. Insida City Limits MD BALTIMORE N/A 1 □ Yas 2 □ No Director 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 21215 5811 PARK HEIGHTS AVE. USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, 11. Marital Status pemit. Pages T and 2 should be filed within 72 hours after Department of Heelih end Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other treumatic event, the Medical Examinat Black. Whita, atc. 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Detes: 1 Nevar Merried Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE Specify: à 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) Collega (1-4or 5+) 4 MACHINIST BALTO. SPICE CO. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be VICTORIO BITTAN FORTUNATA MIMUN PITTAN 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) MERI BITTAN (WIFE) 5811 PARK HEIGHTS AVE. BALTO., MD 21215 20b. Piaca of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete t Surial 2 ☐ Creme CHIZUK AMUNO (ARLINGTON) 10/8/97 BALTIMORE, MD 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician Immediata Causa (Final disease or condition resulting in death) /Medicai Examiner Sequantially list conditions, if eny, leading to immadiata cause. Entar Underlying Cause (Diseasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical the 80 Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? va son lav been signed by should be detac 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy Completed hes 1□ Yaa ZEINo certificate 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 10 1 Hopatient 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? : After t i or Attending P after death. | Director: After Naturel 5 Panding invastigation 1 Yas 2 No 21 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stefe) 28a. Place ot tnjury - At homa, farm, street, tectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29e. Certifian 1 Cartifying Physician: To tha best of my knowledge, death occurred at tha tima, data and piece, end due to the causa(s) and manner as steted. Medical npletely (Check only one) 2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. 29b. Signatura and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) 30339 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) 10 Court Adi Baltimore

72. Registral's Signature

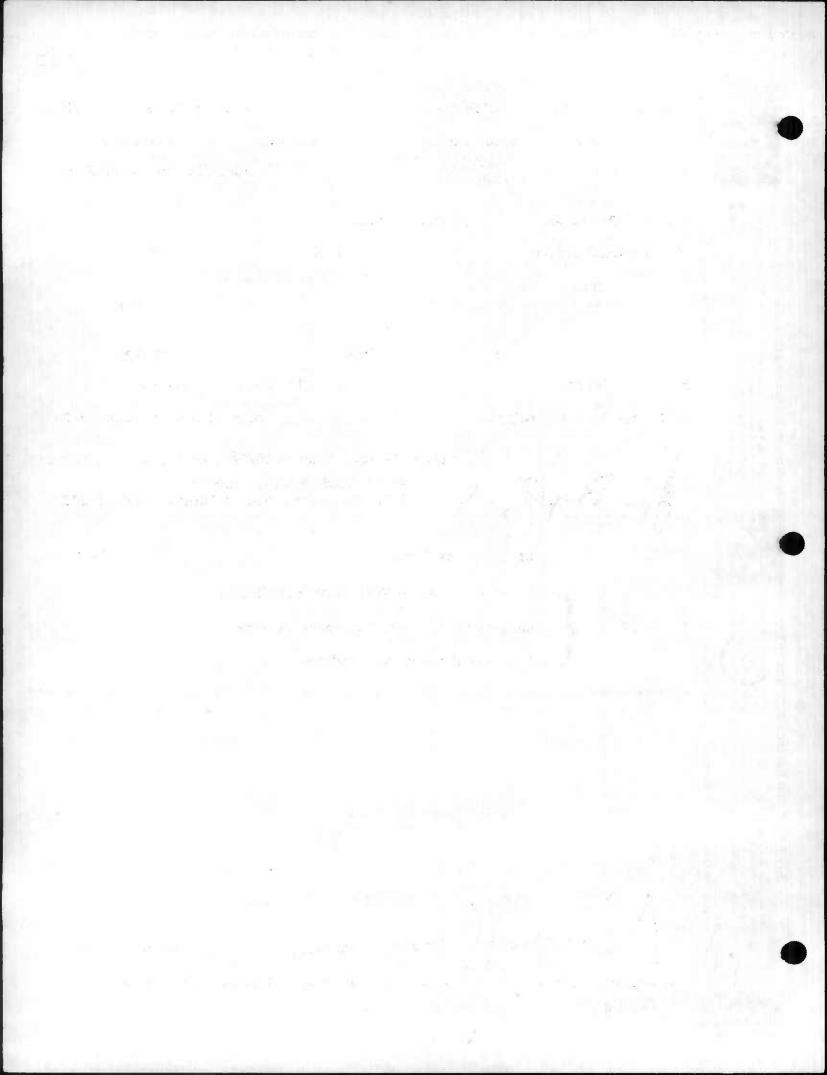
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Registrar



State of Maryland / Department of Health and Mental Hygiene 97 30565

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哥哥		1 Never Married 2 Married	Armed Forces? 1 1 Yes 2 □ No If Yes, Give		1 ☐ Yes 2 🎖 No		no moan, etc.,		ck, White, etc.					
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်			3		oraftsman				Space					
BeC	1	7. Father's Name (First, Middle, Last,	,				eme (First, Middle,							
2		Frank Buttman	1			Elizal	beth	Beverla	ind					
To	19e. Informent's Name/Reletionship (Type, Print) Doris Mae Buttman (wife)  19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, S 226 Endsleigh Ave. Middle River, Mary													
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9000	2	21. Soneture of Fundant Service Licer	nsee 1	F	22. Name end Add	ess of Fecility	al Home F	Δ						
a	1	22. Name and Address of Ferlity Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 2122												
	1	23a Plant Enter the disease, or com	pications that caused the	ne death. Do not e	inter the mode of dy	ring, such es cardi	ec or respiretory e	rrest,	Ap	proximete				
ian	1	Interval Between Onset end Deet												
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ner	disease or condition resulting in deeth)  Cirrhosis of Liver  Due to (or es e consequence of):													
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State of Maryland / Department of Health and Mental Hygiene 30566 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month BARTH 5:00 p.m. MAE ELEANOR OCH /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ST. AGNES HOSPITAL BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | APRIL 10, 1922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 BF MARYLAND 75 214-12-2011 Vrs Director Usuai Residence of Decedent the Maryland 10e. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinat must be notified at Yes 2□No Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 127 S. PAYSON STREET Funerai 21223 U.S.A.

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritai Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0020 1 ☐ Yes 2 XNo þ Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 10TH GRADE HOMEMAKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 12 should be fill hand Mental H is marked oth Be WILLIAM THOMPSON 2 MAMIE SALINE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 Department of Health a Important: If Item 27 is any injury or other trac CHARLES H. BARTH (HUSBAND) 127 S. PAYSON STREET - BALTIMORE, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1₺ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) LOUDON PARK CEMETERY 10/8/97 BALTIMORE HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 23a. Part: Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medicai ANONC 3 DAYS ENCEPHA LOPATAY Examiner Due to (or es e consequence of): Examiner CARDIO - PULMONARY ARREST 3 DAVS physicien end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 88 use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy s ueed Completed page 2 NA 1 Yes 2 No 1 ☐ Yes 2 ☐ No aspital or Attending Physician: hours after deeth. 8 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 M inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 28e. Dete of injury (Month, Day Year) 27. Manner of Death 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred After NA 5 Pending investigation 1 Naturai 1 Tyes 2 No NA 2 Accident NA Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide unerai 29a. Certifier 1 Certifying Phyaician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL RESIDENT Taloner P10871 04,1997 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) PILAR CATON AVE BALT MD 6. ALDRISO ST. AGNES HOSPITAL, 900 31. Dete filed (Month, Day, Year) State

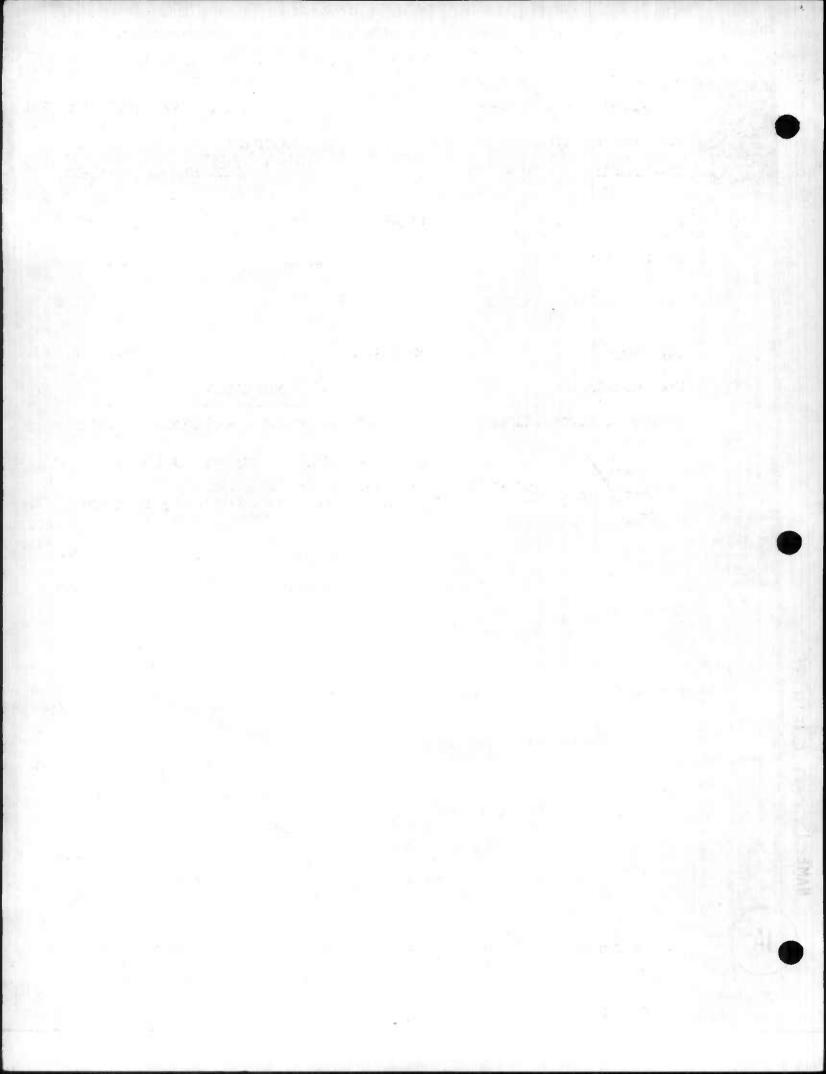
Registrar

OCT 0 9 1997

32. Progistrar's Signature

16000

NAME: Barth, El



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30567 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1997 DAVID A.R. BROWN 8:010W 5 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital 900 S. Caton Avenue Baltimore N/AIf Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1⊠M 2□ F 83 Yrs. SEPT 20,1914 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 2663 DULANEY STREET 21223 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Biack, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STEELWORKER ARMCO STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ARCHIBALD BROWN (UNKNOWN) 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBIN SMITH (DAUGHTER) 317 CONCERT WAY - CATONSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State to Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEMETERY 10/8/97 BALTIMORE 21. Signature of Servica Licansee 22. Name and Address of Fecility
HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 Per the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only contains on each line. Approximate interval Betwe Onset and Death AORTIC NUNCE D13050FD 15 TEARS Due to (or as a consequenca of): Due to (or as a consequence of): Due to (or es a consequence of):

Baltimore, Maryland 21215-0020 perport. Peges 1 end 2 s
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Important: If Item 27 is
any Injury or other trau **Physician** 

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Director

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Completed

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Pages 1 and 2 should be filed within 72 hours effer in ant of Heelth and Mental Hygiena. Int: If Itam 27 is marked other than "natural", or its

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St. Agnes
5. Social Security Number

214-01-9145

10e. Street and Number

8TH GRADE

20e. Method of Disposition

10a. State

MD

/Medical Examiner

physician of the buriel

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filled in by the funeral

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Box 68760.

P.O. |

Records,

Division of Vital

Hospital or Attending

death.

To the Hospital within 24 hours e To the Funeral E

efter death

BROWN

NAME: DAVID

Examiner

Physician/Medical

þ

Completed

Be

Medical

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown

Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULLCONARY DISMAIC GASTROINTESTINA BLEEDING, SEIZUIZE DISORDER

24b. Were autopsy findings evellable prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 20 No Manner of Death

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred

28a. Date of injury (Month, Day Year) 5 Pending Investigation Naturai 2 Accident 3 Suicide 6 Could not be determined 4 ☐ Homicide

1 Yes 2 No Location (Street and Number or Rural Route Number, City or Town, State)

28e. Placa of injury - At home, farm, street, factory, offica bullding, etc. (Specify)

29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number

29b. Signature and title of cartifier M. D.

00052102

29d. Date signed (Month, Day, Year) OCTOBER 5,1997

30. Name and offress of person who completed cause of death (Item 23e) (Type, Print)

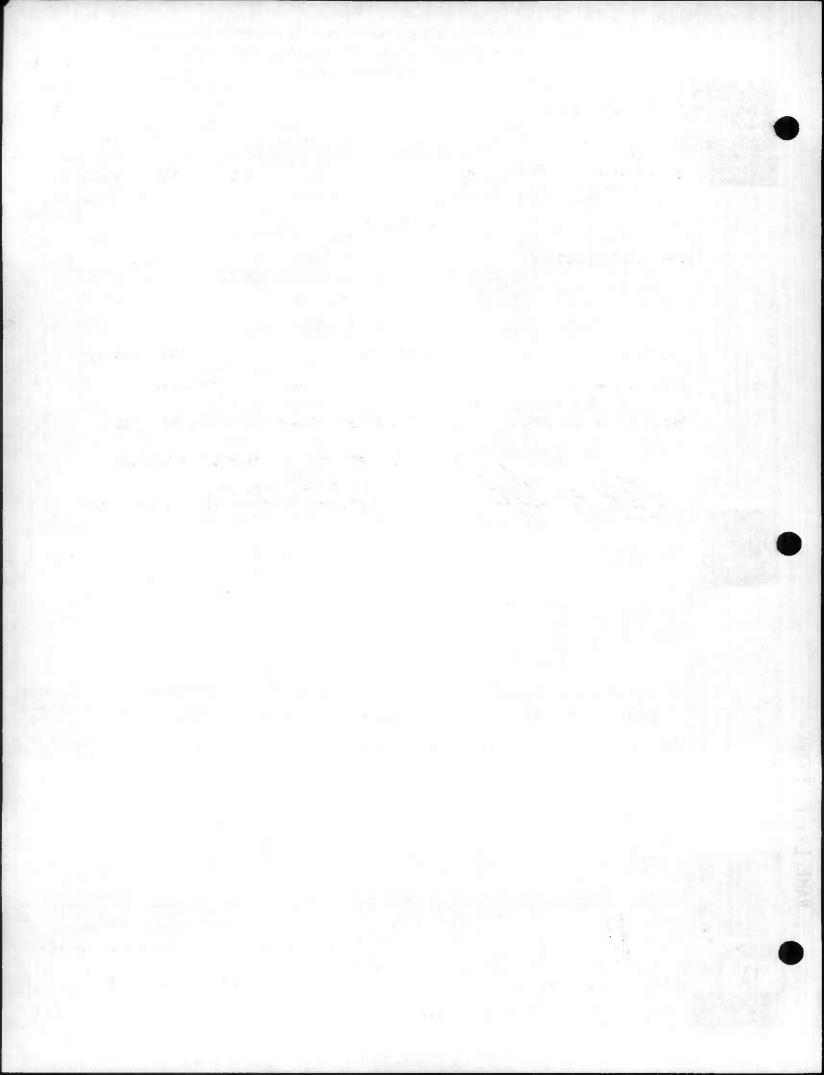
900 (ATON AVE. BALTIMORF, MD 21229 NORBERTU CALZADA MID.

31. Date filed (Month, Day, Year) OCT 0 9 1997

I, ha Day Ison-Randell

State Registrar

DHMH 16 Rev 6/95



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Funeral Director		5. Social Security Number 6. S  216-32-4268  1  Usuel Residence of Decedent	ex 7. Age (	In yrs. last bir	thday) If Under 1 Yee Months Deys		8. Dete of Birth (Month, Dey,	(ear) 17,1905	Country	ARY LAND	
/land		10e. Stete 10b. County	. 1	Oc. City, Tow	n or Location				100	d. inside City Limits	
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ath w	ral	8419 HALLO			313	+34			1.S.A		
72 hours after death with the Manyland 72 hours after death with the Manyland natural; or items 23s or 28s-f show picel Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	er in U,S.	13. Wes Decedent of If Yes, specify Cu		ecify Yes or No- Ricen, etc.)		- American		
72 hours "natural",	ted	15. Decedent's Ed		16e.	Decedent's Usuel Occu	upetion	ti	6b. Kind of Bu	siness/Indu	istry	
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and	Examiner	Sequentially list conditions, if env. leeding to Immediate	b	e to (or es e	consequence of):						
g physician as the buria	Medical E	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	C	e to (or es e	consequence of):						
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ン		BOON P. LIM,	M. D.	7620	YORK ROAD	TOWS	SON, MAR	YLAND	21	204	
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State of Maryland / Department of Health and Mental Hygiene 97 30569

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Exami		4a. Facility Name (If not Institution, giv	e streat and number)				4b. City, Tov	wn, or Loca	ition of Death	4c. Count	y of Death				
		Cumberland Nurs						erlan		Alle	gany				
Funeral Director		5. Social Sacurity Number 6. S  214-16-2571  Usual Residence of Decedent	DM 2RE	ge (In yrs. las 32	Yrs.	If Undar 1 Ya Months Da		Min. 8	Data of Birt (Month, Day May 1	v. Year) 0, 1915	Cou	place (State or Foreign intry) rginia			
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/Medical Examiner	П	Immediate Cause (Final disease or condition resulting in death)  a. Ch. ronic Obstructive Pulmonary Disease 10 yrs													
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		30. Hame and address of person who	ompleted cause of de	eath (Item 23	a) (Type, F	Print)	umb	ser	lang	IN	urs	ing Ctr			
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State of Maryland / Department of Health and Mental Hygiene Item 20a per FH Film G752 10-09-97 rja Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 3.55 PM WILMA G. COOKE OCT /Medical 4a. Facility Name (If not Institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** ST. AGNES HEALTHCARE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 233-44-8245 1□ M 2□ F 69 Director KENTUCKY Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1,☐ Yes 2 ☐ No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1903 BARRY ROAD 21222 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. filed within 72 hours effer 1 Never Married 2 Married 1 Yes 2 No If Yas, Give Year or Dates: 1 ☐ Yes 2 ☐XNo Specify: by Specify. 3X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BARTENDER JAN'S BAR Maryland 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) and 2 should be fill teath and Mental H m 27 is marked oth WILL DEROSSETT SALLY RICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If Item 27 is or other tra MR. RAYMOND G. COOKE 1903 BARRY ROAD BALTO, MD. 21222 altimore. 20b. Placa of Disposition (Name of cametery, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State Purial 2 Cramation 3 Removal from State Septembert III GREEN MOUNT CEMETERY 10-04 BALTO. MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility KACZOROWSKI FUNERAL HOME Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest." MD. 21222 Approximate Onset and Death **Physician** ASPIRATION PNEUMONIA /Medical Immediate Causa (Final DAYS disease or condition resulting in death) Examiner Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown LIVER FAILURE RENAL FAILURE 24b. Were autopsy findings available prior to Be Completed 24a. Was en eutopsy performed? complation of cause of death? SEIZURES this certificate 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 in by the funeral 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending Investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide ò To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signatura and titla of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 10/1/97 11082 NEWS M.D. 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) MEHRA, ST. AGNES HEALTHCARE, BALTIMORE. 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

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NAMES OF THE PARTY 
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Year Crande 6.45 Pm 1997 to ber 6 OC 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore
If Undar 24 Hrs. 8. Data of Bir en If Undar 1 Yaar 7. Aga (In yrs. last birthday)
79 Yrs. Birthplace (State or Foreign Country) Months Days Hours 1□ M 25 F 12/17/1917 Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits **Baltimore** Baltimore 1 Yas 2 No 10f. Zip Coda 10g. Citizen of What Country? 4507 Raspe Avenue 21206 U.S.A. 14. Race - Amarican Indian, Black, White, atc. White 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working iifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Home Housewife 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middia, Maidan Surnama) Charles J. Savlor Mary Rose Murphy 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routs Number, City or Town, State, Zip Code) Sameul Carroll Crandell 4507 Raspe Avenue Baltimore, Maryland 21206 20b. Placa of Disposition (Nama of cematary, cramatory or other piace) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 10/10/97 Baltimore, Maryland Garrison Forest Cemetery 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206 23a. Part1. Entar tha disaase o com shock, or haart failura. List only math. Do not antar tha moda of dying, such as cardiac or respiratory arrest, Approximate Interval Batween Onsat and Death Dua to (or as a consequence of) Pseudomonas Dua to (or as a consequence of) periton Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown eno Sarcom 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yas 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of 1 ☐ Yas 2 ☐ No 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

/Medical Examiner USB signed by the a Records, P.O.

**Physician** 

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

permit. Proper 1 and 2 should be filed within 72 hours efter death with the Menyland Department of Health and Mental Hygiene.

Theorems 18 terms 7 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat mark be notified at

Baltimore: Maryland 21215-0020

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5. Social Sacurity Number

10e. Street and Number

20a. Mathod of Disposition

Immediata Causa (Final disaasa or condition rasuiting in death)

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10a. State

Director

Funeral

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To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica

Division of Vital

Examiner

1 Yas 2 No 27. Mannar of Death 1 Natural 2 Accident 3 Suicida 4 Homicida

25. Was casa refarred to medical axaminar? 5 Panding invastigation 6 Could not be datarmined

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Baltimore MD 21202.

29a. Cartifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

29b. Signatura and titla of certifiar

october 6, 1997

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) VIJOY Pethkar 301 St. Paul VIJOY 31. Data filed (Month, Day, Year)

OCT 0 9 1997

22. Registrar's Signatura who Davidson-Randoll

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State Registrar

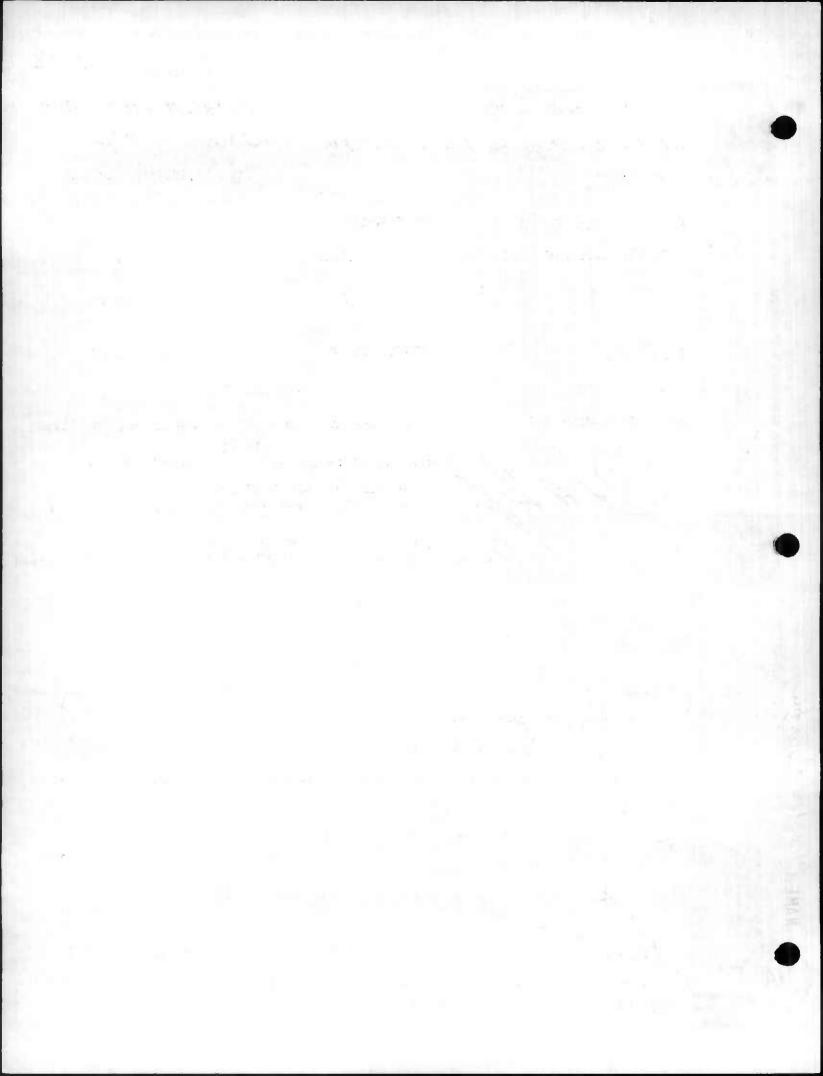
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1		30. Nama and address of person who Kovin H. Schub	GS gun)			Print) - Ave	une	B	ultrus	e M	ary/on	e	212	29		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1949 YA.M. ORIS 03 OCT. 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth LEVINDALE HEBREW GERIATRIC CENTER HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Deta of Birth
(Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Deys Hours 1 M 2 F 73 213-20-5456 FEB. 12, 1924 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3026 21234 CHESLEY U.S.A 11. Maritel Status Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Married 1□ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHONE CO. OPERATOR 10 NA 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CARR ARTHUR UNKNOWN 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREENWOOD AVE - BALTO., MD. 21206 KAREN CARR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State BALTIMORE CITY 4 ☐ Donation 5 ☐ Other (Specify) 10/6/97 GREENMOUNT CEM, Funeral Service Licensee 22. Name and Address of Fecility HARTLEY MILLER FUNERAL HOME 7527 HARFORD RD. - BALTO, MD. 21234 233 Puril Enter the distance or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in deeth) CSDIVATORI Due to (or as e consequence of): respiratory Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): pheumonia Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 □ Probably 4 □ Onknown Fibrillation 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was en eutopsy 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 28a. Date of tnjury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No

physician 8 certificate ed by the attending detached for use as Division of Vital Records, P.O. signed by d be detact peed Pas Pas page 2 Attending Physician:

Physician/Medical p Completed

Examiner confficate ## (medi) Aftar

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

2 should be filed within 72 hours after death and Mental Hygiene. Is marked other than "netural", or items 23.

permit. Pages 1 end 2 st Department of Health and Important: If Item 27 Is n any injury or other traun once.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

with the Maryland

after death Director:

Certification:

Medical

State Registrar

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Natural 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) end menner as stated. On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and manner stated. 29b. Signature end title of confi 29c. Licensa number 29d. Date signed (Month, Day, Year)

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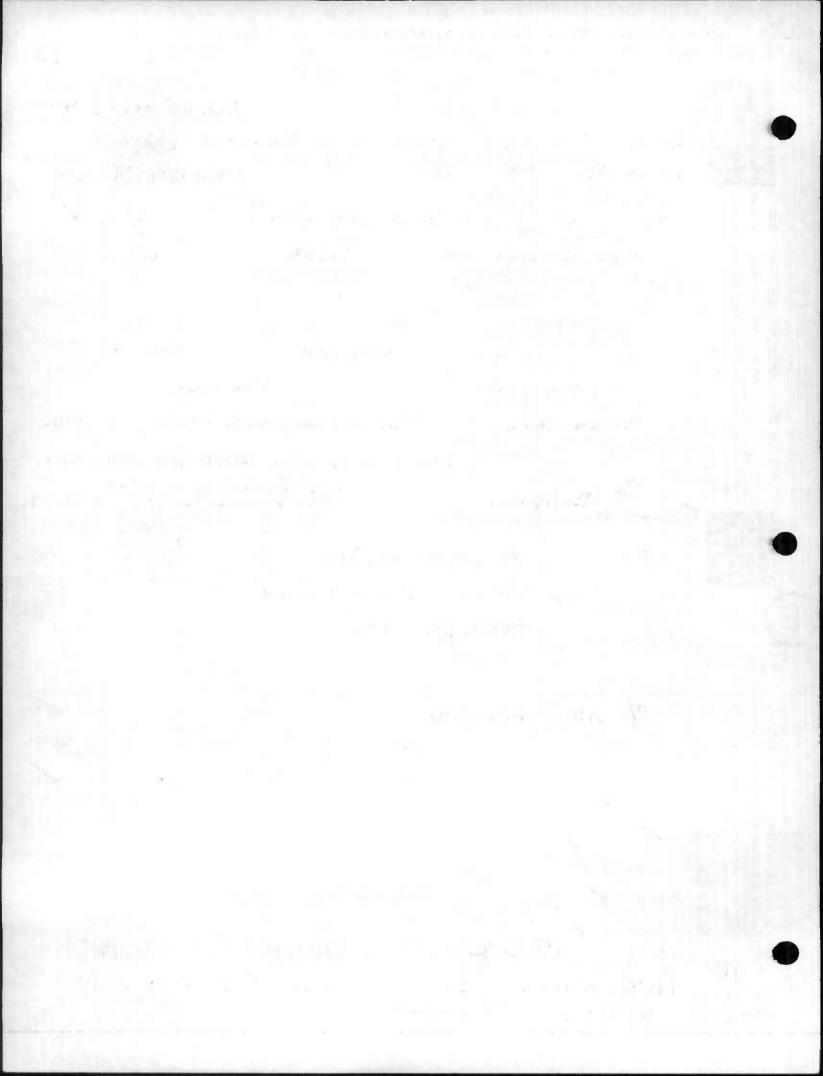
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

OCT 0 9 1997

3901 Greenspring Weber, mid Balto, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

**DHMH 16 Ray 6/95** 

To the Hospital or within 24 hours a To the Funeral D



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth aniele **Physician** 40 Srian october /Medical 4b. City, Town, or Location of Death 4a. Fecility Neme (If not institution. give street and number 4c. County of Death Examiner 110 5. Sociat Security Number If Under 1 Year If Under 24 Hrs. 6. Date of Birth Age (In yrs. last birthday) **Funeral** oplace (State or Foreign Deys 216-76-8893 Usuet Residence of Decedent Hours 10 M 20 F Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director mor land 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country; 8 Items 23a Funerai Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Ortgln? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Meritei Stetus American Indian, perfit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" — say Injury or other traumatic averages. Bteck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Hmerican THO Completed 15. Decedent's Education fy only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry Elementary/\$econdery (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme, James (mother 19a. Informent's Neme/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removet from State reenmount 4 Donetion 5 Other (Specify) remotor 22. Name end Address of Facility 21. Signature of Funerel Service Liceni Joseph 12/6 . Nor 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart filling. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and the bunal-transit The law requires that the death certificate be executed Sequentietly tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initieted events resulting in deeth) Last Due to (or es e conseguence of) P.O. Box 68760, Physician/Medical the Due to (or es e consequence of) attending p ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach Unknown 3 Probably 1 Yes 2 No Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? should Completed 24e. Wes en eutopsy performed? page 2 s NP 2 No certificate 1 Yes Hospital or Attending Physician: director Be 25. Wes cese referred to medicel examiner? 26. Piece of Deeth (Check only one) examiner? Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this funeral Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? After Naturel 5 Pending investigation n 24 hours after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Funeral D 17 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of deeth (Item 23e) (Type, Print) 30. Neme and eddress of person who 01.0

State Registrar

31. Dete filed (Month, Day, Year)

OCT 0 9 1997

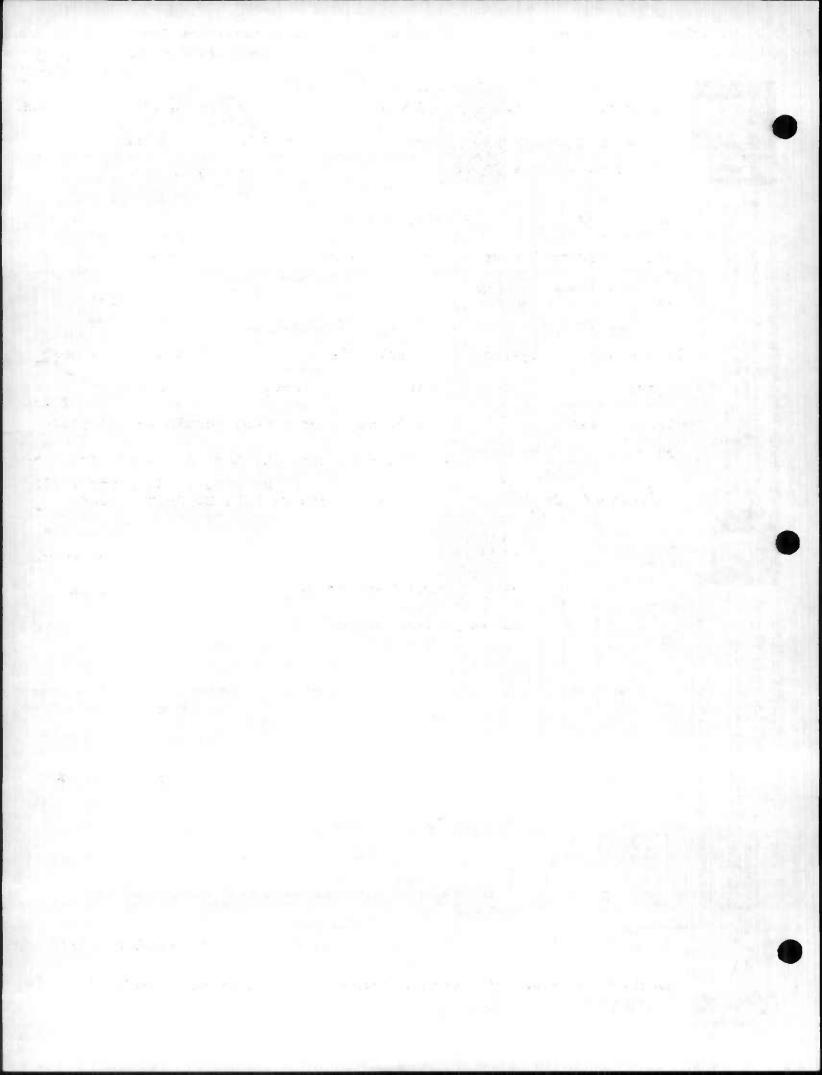
32.1

egistrer's Signeture

a Davidson

State of Maryland / Department of Health and Mental Hygiene 97

	•			Ce	rtificat	e of	Death			Reg. No.			
	1. Decedent'a Neme (First, Middle	, Last)							2. Dete of De Month	eth _Dey	V.		. Time of Deeth
nysician Medical	Isadora	Ε.		DUNC	AN				Octobe	r 8,	1997	eer	7:49 A.M
kaminer	4e. Fecility Neme (If not institution	give street end n	um <i>ber)</i>				4b. City, To	wn, or Lo	ocation of Deet	4c. C	County of I	Deeth	
	Franklin Squ	are Hosp	ital Ce	enter				seda.			Balti	more	
erai ctor	5. Social Security Number 218-12-0014	6. Sex 1□ M 2√2 F	7. Age (In yrs 78	. lest birthday, Yrs.	Months	Deys		24 Hrs. Min.	8. Date of Bir (Month, De 01-01	th ly, Year) -19	9.	Birthplece Country) SC	(Stete or Foreign
Be Completed by Funeral Director	Usuel Residence of Decedent  10a, State  10b, County		10c C	ity, Town or L	ocation							404	Include Ober A leading
70	Md. NA			altimo									Inside City Limits  1  Yes 2 No
o c	10e. Street and Number		Di	ar crim	10f. Zlp	Code			1	10a Citize	on of Wha	at Country?	17
Funeral Director	2729 Superio	x Augni	10			123	1			US		st Country ?	
Jera	11. Meritel Stetus	12. Wes Dec	edent Ever in L	J,S. 13.				lgin? (Sp	ecify Yes or No Ricen, etc.)			American I	ndien,
by	1 Never Married 2 Merrie  **Moved 4 Divorced	Armed F ed 1 ☐ Yes If Yes, G Year or I	XXNo ive		If Yes, spe				Ricen, etc.)			White, etc. Blac	k
ed	15. Decedent' (Specify only highes.		)	16e. Dece	dent's Usu	al Occu	petion	t of work	ina	16b. Kin	d of Busin	ness/Indust	ry
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2	Jack			Walker			Nan				Brice	_	21224
	19e. Informent's Neme/Reletionsh	lp (Type, Print)											de) 21234
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	Demaid	D yum	son						101 E.		th	Aven	ue
	23e. Pert1. Enter the diseese, or of shock, or heart feilure. List of	complications that only one cause on	ceused the dea eech line.	th. Do not en	ter the mod	de of dy	ing, such es	cerdiec	or respiretory e	rrest,		Inte	proximete erval Between
	Immediate Course (Final											On	set end Deeth
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lea	ceuse. Enter UnderlyIng Ceuse (Disease or injury that initiated events	c. Cor	onary A			ise							
Medical	resulting in deeth) Last		Due to (	or es e consec	quence or):								
cian		d											
Physician	Part II. Other eignificent condition	s contributing to d	leath but not res	sulting in the u	inderlying o	euse gi	iven in Pert I	l.					cause of death?
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d by									24a Was	en eutops	v 2	24b. Were a	autopsy findings
Completed									perfo	med?		eveilab	ble prior to etion of cause
E G												of deat	***
	OF Mean age referred to me first								10	- 1	No	1 🗆 Ye	s 2 No
Be C	25. Wes cese referred to medicel examiner?	Hospital:				Ot	her:		h (Check only o	-			
: To	1 ☐ Yes 2 No 27. Menner of Deeth	28e. Dete		ER/Outpatle		JA	4 LI NI		me 5 Resident			(Specify)	
tion	1 Netural 5 ☐ Pending 2 ☐ Accident Investige	(Mor	nth, Day Year)	Injury	М	28c. Inju Wo	ork? ]Yes 2□			,,			
Certification:	3 ☐ Suicide 6 ☐ Could no	ot be	e of Injury - At h	ome, ferm, st					28f. Location (	Street and	Number o	or Rural Ro	oute Number,
ert	4 ☐ Homicide		ling, etc. (Speci			,			City or To	wn, Stete)			
edical C	29a. Certifier 1 Certifying (Check only one) 1 Medicei E	Physician: To the xaminer: On the b	e best of my kno esis of exemine	owledge, deet etion end/or In	h occurred vestigetion	at the ti	ime, dete en opinion, dee	d place, th occurr	and due to the ed et the time,	ceuse(s) a dete end p	nd menne plece, end	er es stated I due to the	d. cause(s)
X	29b. Signeture and title of certifier				29	c. Licen	se number			29d. Dete	signed (A	Month, Day	Year)
	A Alas	W.D .				D.	38754			00	tobe	r 8,	1997
	30. Neme and address of person w	the completed care	se of death (Ite	m 23e) /Time	Print)							,	
						ec T	) wai == =	D -	1+4	MD	2122	7	
State	Malika Waseem 31. Dete filed (Month, Day, Year)		0000 Fra		oqua:	LEL	TIVE	ьa	ltimore	, PID	7177	7	
State gistrar	31. Dete filed (Month, Day, Year)	Juna.	avidson-	Pandelle									



State of Maryland / Department of Health and Mental Hygiene WILLIAM C. DAVIS 30576 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 7, 1997 **Physician** William Davis OCTOBER 12:00 AM /Medical 4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Daath 4c. County of Death BALT IMORE Examiner DUNDALK WALNUT AVENUE 121 If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaer) 5. Social Security Number If Undar 1 Year 7. Aga (In yrs. last birthday) **Funeral**  Birthplace (State or Foraign Country) 1XX 2 F Days 223-44-5667 62 Yrs. Director May 23,1935 MD Usual Rasidenca of Dacedant 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits 28a-f show must be notified MD Director Baltimore 1 ☐ Yas 2 TXTX Turners Station the 10a. Straat and Number 10f. Zip Code 10g. Citizan of What Country? 6 121 Walnut Items 23a Ave. 21222 USA death Funeral 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☐ Yas ★★No If Yas, Giva Year or Datas: 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 72 hours efter 1 Navar Married Marriad 21215-0020 natural', or 1 ☐ Yas XXNo Specify: **Black** py Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Dacedant's Education 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Spacify only highast grada complated) (Giva kind of work dona during most of working lifa. DO NOT use retired) nd Mental Hygiene. merked other than Elementery/Secondery (0-12) Collaga (1-4or 5+) Es. Maintenance Balto. Co. Schools 12th Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) Be 8 and Mental Pages 1 and 2 should 0 Zack Davis Dorothy 19a. Informant's Name/Ralationship (Type, Print) nerit of Health and nt: if item 27 is m y or other 19b. Mailing Address (Streat end Numbar or Rural Route Numbar, City or Town, Stete, Zip Coda) Maude M. Davis/wife Walnut Ave. Balto., MD 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, crematory or other placa) 20c. Location - City or Town, Stata 1 XX rial 2 ☐ Cremation 3 ☐ Ramoval from Stata Decembert
Important: If
any injury o 4 ☐ Donation 5 ☐ Other (Spacify) Mt. Sinai Baptist Cem.10/12 Ivor, VA 22. Nama and Address of Facility James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD Pand Entar tha disaasa, or complications that caused the death. Do not antar the mode of dylng, such es cardiec or respiretory errest, show or heart failure. List only one ceuse on eech line. Intarval Bety Onsat and Daath **Physician** Immediate Ceusa (Final Arteriosclerotic Cardiovascular Disease disaase or condition rasulting in daath) Examiner Dua to (or es a consequance of) Examiner requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): 68760 Physician/Medical Dua to (or as a consaquence of): Box etter P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. by Completed 24a. Was an eutopsy 24b. Wera autopsy tindings complation of cause of death? INSPECTION 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No of Vital Be 25. Was case raferrad to medical 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yas 2 No OL 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mennar of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Division 1 XNetural 5 Panding invastigation Injury Attending death. 1 Yas 2 No 2 Accidant ector: 3 Suicida 6 Could not be datarminad in by t 28e. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, State) ofter 4 ☐ Homicide 0 Hospital 24 hours 29a. Cartifian within 24 hou To the Fune completely fi Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) and manner stated. 943 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) O.C.M.E. OCTOBER 7, 1997

J. Laron Locke M.D. 31. Data filed (Month, Dey, Yaar)

OCT 0 9 1997

111 Penn Street, Baltimore, Maryland 21201

State Registrar

30. Name and address of person who completed cause of death Prom 23a) (Type, Print)

32. Registrar's Signatura who Davidson · u

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2:50 P.M. /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death County of Death Examiner If Undar 24 Hrs. 8. Data of If Undar 1 Yaar 5. Social Security Number **Funeral** Days Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 DHNo Director 10g. Citizen of What Country? ò items 23a Funeral 12. Was Decedent Ever in U.S. Armad Forcas? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Never Married 2 Married natural, or Baltimore, Maryland 21215-0020 1□ Yes 2☐No Specify: Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education fy only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ond Mental Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 19a. Informant's Name/Ralationship (Type, Print) Department of Heelth e Important: if Itam 27 Is any Injury or other tra 20a. Method of Oisposition 20b. Place of Disposition (Name of cametery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donatiop 5 ☐ Other (Specify) the disease, or complications that caused the death. Do not enter the mode earl ailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Haemorr Left /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of): Teen Physician/Medical Examiner Ten hers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death?

P.O. signed by the Records, Division of Vital Certification: To

certificate To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p eral Director: After this filled in by the funeral

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Be Completed

Medical

2/0 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 6 Could not be determined 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signatura and title of certifier

1 Yes 20 No

27. Manner of Death

1 Natural 2 Accident

3 Suicida

29a. Certifier

4 \ Homicide

29c. Licanse number

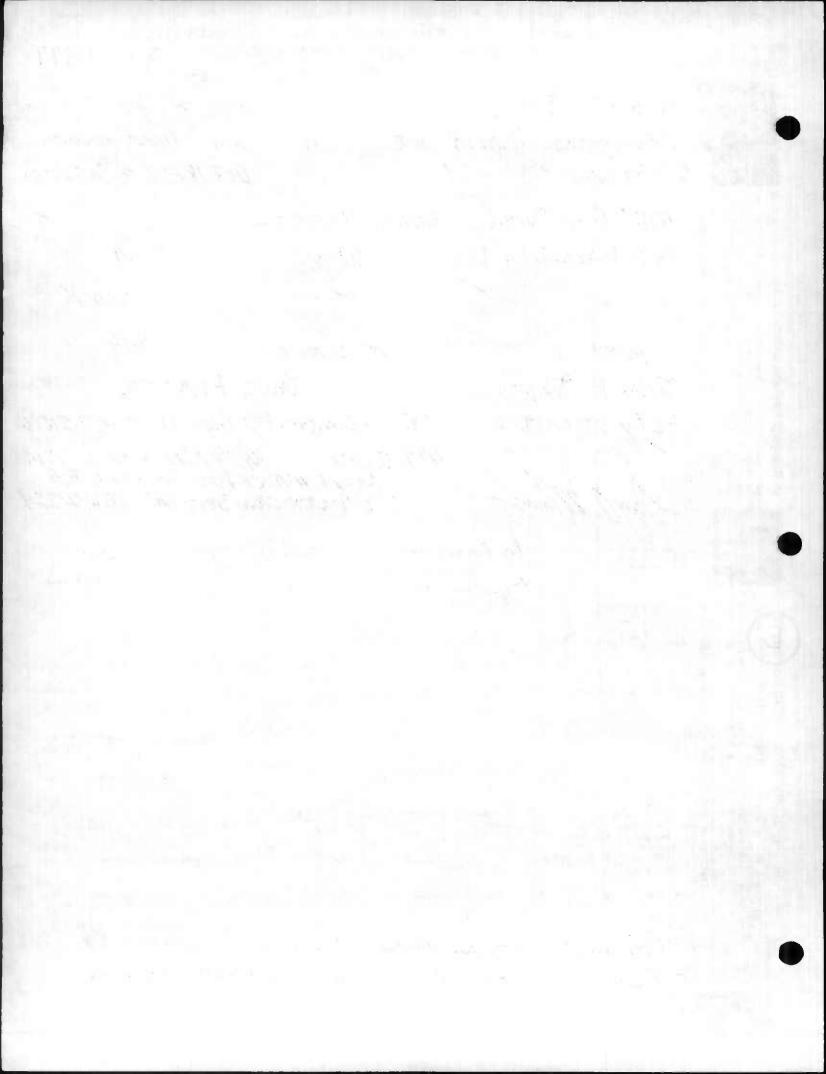
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

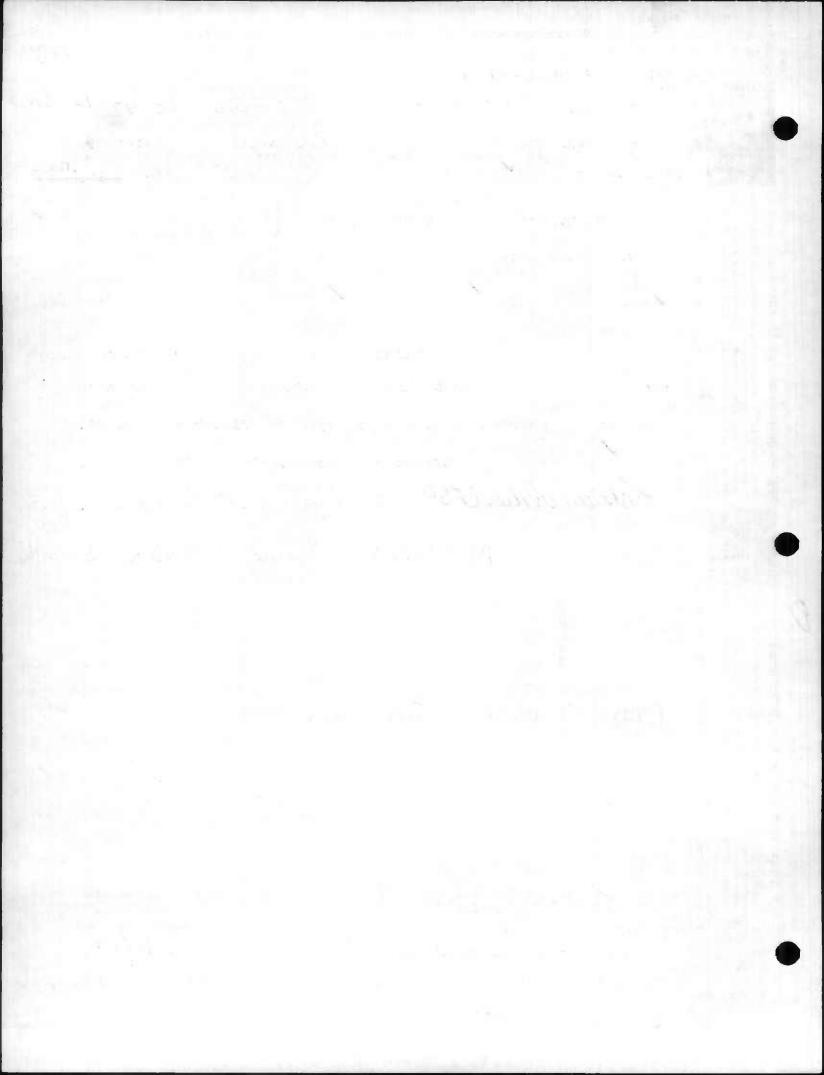
V. CYRIAE-M-9 8109 RITCHER HWY

31. Date filed (Month, Dey, Year) State Registrar

32. Registrar's Signature



			ITEM: 9 per		2 10-9-97 e			tificate of	Health and M Death		giene g Reg. No.	1 3	0578	
	Physic	ian	1. Decedent's Name (Fin		,	BAUG	11			2. Date of Dea Month	ath Day	Year	3. Time of Death 12:45/	
	/Medi		CONSTA				#			10	08	97	12.131	
	Examination Examination Examination Examination Example: Examination Examinati	ner	Forest H 5. Social Security Number 216-28-15	aven I	Nursing		ot birthdey) Yrs.	If Under 1 Yeer Months Days		8. Date of Birt	Bal	9. Birthpl	ore lace (State or Fore try): MIDMORE timocMI	ngien O
	pue M.		Usual Residence of Dece 10a. State 10b.	County		10c. City,	Town or Lor	cation					Od. Inside City Lim	its
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	or 28s	rec	10e. Street end Number			1	, , , , ,	10f. Zip Code			10g. Citizen of W	/hat Coun	try?	
	th wit	alD	315 Ingl	eside	Ave.			2122	8		USA			
020	ours efter death al', or flems 23 Examiner musi	by Funeral Director	11. Maritel Status  1 Never Married 3 Widowed 4 1		12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	No.		Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- America k, White, e : Whi	etc.	
21215-0020	filed within 72 hours efter Hygiene. rther than "natural", or Ne ent, the Medical Examine	Completed		Decedent's Edily highest grad			16a. Deced (Give life. L		petion during most of work ad)		16b. Kind of Bu			
pu	e filed el Hygid other vent,	BeC	17. Fether's Neme (First,	Middle, Last)		1			18. Mother's Name	1.1				
yla	should be nd Mentel marked o	70	Stanisla	V	V	lenska	itis		Maria		Za	vans	ka	
Maryland	Is mar		19a. Informent's Neme/F						t and Number or Run		,			
Baltimore, I	permit. Pages 1 and 2 should be filed Department of Mentel Hy, important: If tem 27 is marked other any injury or other traumatic event, ence.		Constance  20a. Method of Disposition  1 Burial 2 Cre 4 Donation 5 0	on omation 3⊡I	Removal from State	20b. Plac cerr	oe of Dispos netery, crem	sition (Neme of netory or other ple	oca)	Date	20c. Location -	City or To	wn, State	
alti	permit. Pa Department Important: any injury once.		21. Signature of Puneral			GIE		Name and Addre	ematory1	0/0	Baltim	ore	MD	_
Ö	Depa Impo any ir		Kathe	een le	letter (	FSF	Do not ente	avid J 311 Edr	• Weber mondson ing, such as cardiac	Funera Ave. B	l Home	re M	D. 2122	29
	Physician /Medical Examiner	er	23a. Pert1. Enter the dis shock, or heert failu Immedlete Cause (Finel disease or condition resulting in death)	ire. List only o	a.	Due to (or a	STA	FIC				1	Intervel Between Onset and Death  Smm1	
x 68760,	hath certificate be executed ether of the ording physician and for use es the burial-transit	Medical Examiner	Sequentially list condition if any, leading to immedia cause. Einer Underlying Cause (Disease or injury that infilieled events resulting in death) Last	ns, ate	b	Due to (or a					·			
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	The ete h	Con								101	res 2000	1 🗆	Yes 202 No	
of Vital	Physician: The I this certificete ha ral director, page	Be	25. Was case referred to exeminer?	-	Hannita I.				26. Place of Deat	h (Check only o	ne)			-
of	Physic this c	1°	1 ☐ Yes 2 ☑ No 27. Manoer of Death		Hospital: 1 ☐ Inpati		VOutpatient	3LI DOA			lence 6 Othe		)	
o	After fune	tou	Natural 5	Pending investigation	28a. Dete of Inju (Month, De	by Year)	8b. Time of Injury	28c. Inju Wo M 1	rk? ]Yes 2 □No	28d. Describe i	now injury occurr	ea		
Division	To the Hospital or Attending Phys within 24 hours effect death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Placa of In building, e	jury - At home tc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street end Numbern, Stete)	er or Rura	Route Number,	
	To the Hospital within 24 hours of the Funeral completely filled	edical	29e. Certifier (Check only one)	Certifying Phy Medical Exami	sician: To the best iner: On the besis of and manner si	of exemination	edge, death n and/or inv	occurred at the ti estigation, in my	me, date and plece, opinion, death occurr	and due to the ored at the time,	ceuse(s) and <i>m</i> a date and place, e	nner as st and due to	ated. the cause(s)	
	Tot	×	29b. Signature and title o	f cartifier	u Lal	eha	ii	29c. Licen:	se number		29d. Date signed	(Month, 1	Jey, Year)	
	5		30 Name and address of TASNEEW	1 LA	ompleted cause of	death (Item 2:	3a) (Type, I	PARK	HEIGH	As A	e BAR	101	11) 2120	18
	Sta Registr	-	31. Date filed (Month, De OCT 09 19	y, Year)	32. Regist	rar'e Signetur	482							



State of Maryland / Department of Health and Mental Hygiene 97 30579

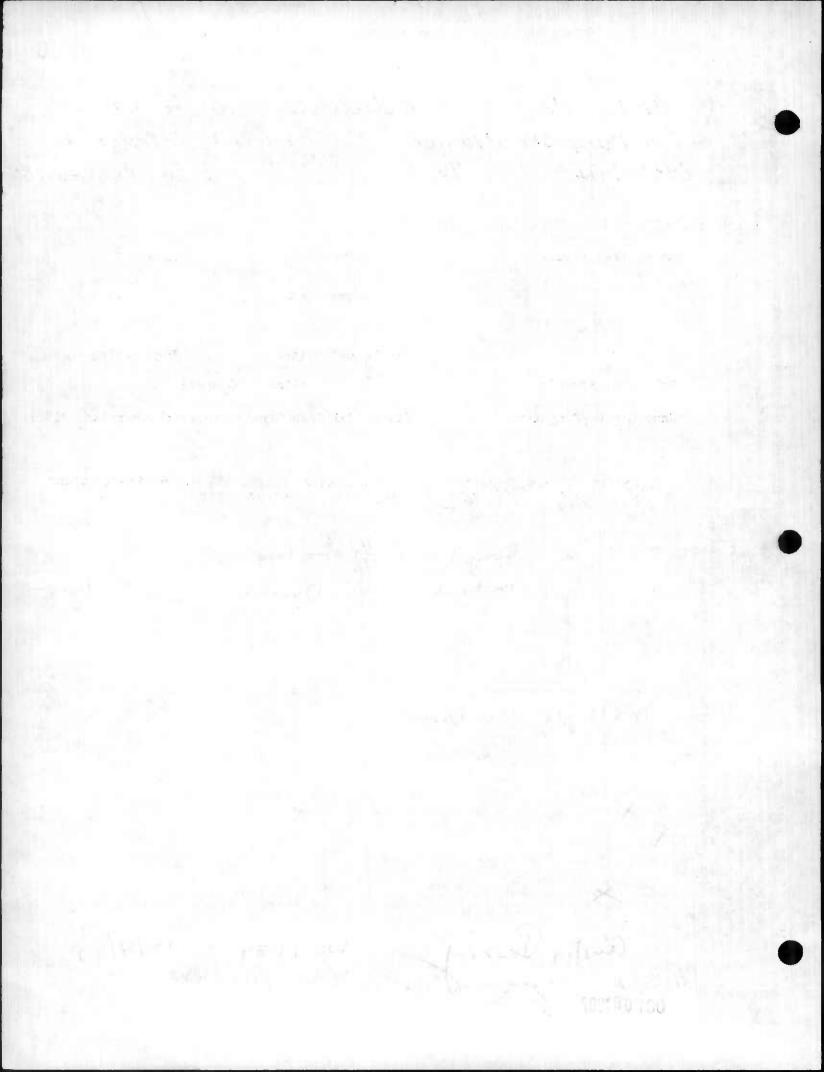
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Physician Medicai/		NATHA	NIEL	EBANK	S						SEPT.		997	6:41pm
Examiner		la. Facility Nema (If not	t Institution, giv	re street and nu	umber)				4b. City, T	own, or Lo	cation of Death	4c. Count	y of Death	
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uneral		5. Sociel Security Numb		Sax	7. Aga (In	yrs. lest birthde		Under 1 Yea		r 24 Hrs.	8. Date of Birth	h Voorl	9. Birthr	piece (Stata or Fora
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oper must be northed oper must be northed Funeral Director	e .	11. Merital Status		12. Wes Dec	cedent Ever	in U,S. 1	3. Was [	Decedent of	Hispenic O	rigin? (Spe	city Yas or No-		ce - Amaric	
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al'.o		3 ☐ Widowed 4 ☐	Divorced	If Yas, G Yaar or [			1 🗆 Y	ras 2 √ N	o Specify	:		Specia	ty: B.	lack
Nor than "natural", or items 23a or 28a-f show it, the Medical Examination must be northed at Completed by Funeral Director	9		Decedant's E			16a. De	cedant's	Usual Occ	upation			16b. Kind of B	usinass/in	dustry
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event, Be Co		17. Fathar's Name (Firs	t, Middla, Last	)					18. Moth	ar's Name	(First, Middle,	Maldan Sumai	me)	
matic e	0	Wallace	Ebank	S					Oph	elia	Haski	ns		
other traumatic event,		19a. informant's Neme/	/Ralationship (	Type, Print)		19b. M	ailing Ad	Idrass (Stre	et and Numi	er or Run	i Routa Numbe	r, City or Town	, Stata, Zip	Code)
27 is m r traum		Angela E	banks			60.	4 K.	Che	rry	Cres	t Rd.,	Balto	. MI	D 21225
item 27 other tr	2	20a. Method of Dispositi				Oh Place of Di	sposition	(Nama of		T		20c. Location		
눌		1 Burial 2 Cr 4 Donetton 5 C				ing Me		y or other p			10/7	Danda	11a+	own, MD
mportant: any injury ance.	-	21. Signature of Funara		• •		Ing m			rass of Feci		10//	Kanua.	1156	JWII, EID
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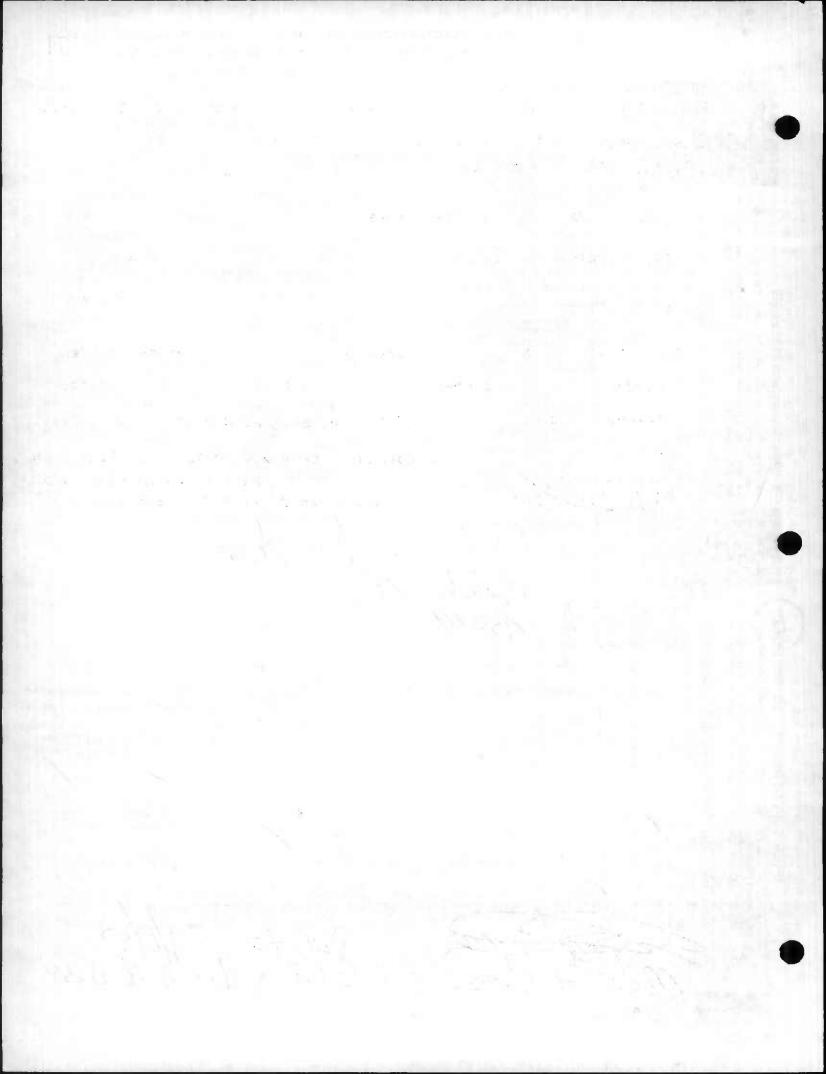
State of Maryland / Department of Health and Mental Hygiene 97 30580

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Director	043-12-7472 16	11/100	nor		tred	erick	Tr	edel	ICK
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	Toa. State	100	: City, Town o	Location				10	d. Inside City Limits
	Maryland Frederic	k ]	Freder						1 ☐ Yes 2√ No
	10e. Street and Number			10f, Zip Code			10g. Citizen of	What Counti	y?
	200 E. 16th Street			21701			U.S.A.		
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by	1 Nevar Married 2 Married 3 Wildowed 4 Divorced	1 ☐ Yes 2 ☐ No if Yes, Giva Yaar or Dafas:		1 ☐ Yes 2 ☐xN		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specif	1.77 4	
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ple	(Specify only highast grade Elementery/Secondary (0-12)	College (1-4or 5+)	- (C	live kind of work don le. DO NOT use retir	e during most or wi red)	orking			
lo l	12	1		Technical	Writer		Engir	neerin	g
Be C	17. Father's Nama (First, Middle, Last)					eme (First, Middle	-		
ToE	Robert R. Edwards	3			Alice	S. Goode	e11		
1-1	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. N	ailing Address (Stree	et and Number or F	Rural Route Numb	er, City or Town.	State, Zip C	Code)
	Jane Cannon/daugh	iter		14 Bridal					
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		b. Place of D	sposition (Neme of crematory or other pi		Date	20c. Location		
	4 DiDonation 5 Tother (Specify)								
	21. Signatura of Funeral Service License Ronal d S. Wa	de, Director	r	State Ana	tomy Boa	rd, 655	W. Balt:	imore	Street
	1. hnoull	11/1000		Baltimore					
	23a. Part 1 Enter the disease or complishood, or heert failure. List only or	cations that caused tha d	leath. Do not	enter the mode of dy	ing, such as cardie	ac or respiretory a	rrest,	1	Approximete Interval Between
1	aroun, or reality tallete. Elst only of	e cause on each mie.							Onsef and Death
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r	resulting in death)	- Conjoi	O lor es e cor	Head and	Date.	×.			· cch
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edical Examiner	Cause (Diseasa or Injury that initiated events	, Due to	. /						
큥	resulting in death) Last	Due	o (or as a con	sequence or):					
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la la									
Physician	Part II. Other significant conditions con	tributing fo death but not	resulting In th	e underlying cause g	iven in Pert I.	23b. Did	lobacco usa co	ntribute to t	the cause of death?
	multiple	myel	(hanka			1 🗆	Yes 2 200	3 Proba	ibly 4 Unknow
by		71				-			
Completed							an autopsy rmed?	avaii	e autopsy findings lable prior to
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0						10	Yes at No	10	Yes 2□ No
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To	examinar?	ospital:	2 ☐ ER/Outpe	tient 3 DOA O		Home 5 ☐ Resid		or (Specify)	
	27. Manner of Death	28a. Date of Injury	28b. Tim				now injury occur		
후	1 Natural 5 Pending invastigation	(Month, Day Year	r) Inju	y Wo	ork? ⊒Yas 2∐No		,,,,,		
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	200 000000			NAME OF TAXABLE PARTY.					
edical	(Uneck only 2 Medical Examin	Iclan: To the best of my i er: On tha basis of axam	knowledge, de ination and/o	eth occurred at the to Invastigation, in my	ime, date and piec opinion, death occ	e, and due to the urred at the time.	cause(s) and ma date and place,	anner es stat and due to ti	red. he cause(s)
	one)	and manner stafad.	The sales of			The way History			
Σ	29b. Signature and title of certifier	(3)		29c. Licen	ise number		29d. Date signe	d (Month, De	ay, Year)
	aution	Vers	1	13	00969	98	10	14/9	1
1 -	30 Name end addrass of person who con	npleted cause of death (	torn 3e) (Ţy	pe, Print)		nat			
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	11057110/ PA	And Minney Comments	1/1/1/	H IIIdill		11 11111	U		



Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Month Lillie Fields 97 05, 11:30am October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Nursing Center NA BAltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) Md . **Funeral** 214-20-2868 1 □ M 2 🖾 F Days Yrs Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23s or 28s-f show Md. NA Director Baltimore ty Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1601 E. Belvedere Avenue 21239 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indien, Black, White, etc. after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1□ Yes 2 No by Specify: Black 3€ Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Heaith end Mental Hygiena. ant: If Item 27 Is marked other than Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Domestic various trades 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Thomas George Nettie Hicks 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Darlene Fields 843 Benninghaus Road Baltimore, Md. 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata \*Burial 2 Cremation 3 Removal from State Department of Important: If eny injury or once. New Cathedral Cemetery 10-10-97 Baltimore, Md 4 ☐ Dohation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.MArch FH 1101 E. North Avenue 23e. Pert T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Physician /Medical Immediete Cause (Finai diseasa or condition resulting in deeth) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of) for use es Box P.O. ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records. by this certificate has been si 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No Division of Vital or Attending Physician: Be 25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To s after death. al Director: After this 27. Manper of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homiclde To the Hospital c within 24 hours a To the Funeral E completely filled 11 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and goa to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certific 29d. Date signed (Month Day, Year) N se of death (Item 23e) (Type, Print) 601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 9 199 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 30582 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Marion C. Ford 5, 1997 8:53 AM Oct. /Medicai 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer) Aug. 16, 1923 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** 1⊠M 2□ F Maryland 74 219-16-1864 Yrs. Director Usuei Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Itams 23a or 28a-f short ther must be notified at Maryland Calvert Dunkirk 1 Yes X No Director 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 681 Fairhaven Road 20754 U.S.A. Funeral 12. Wes Decedent Ever in U.S.
Armed Forces?

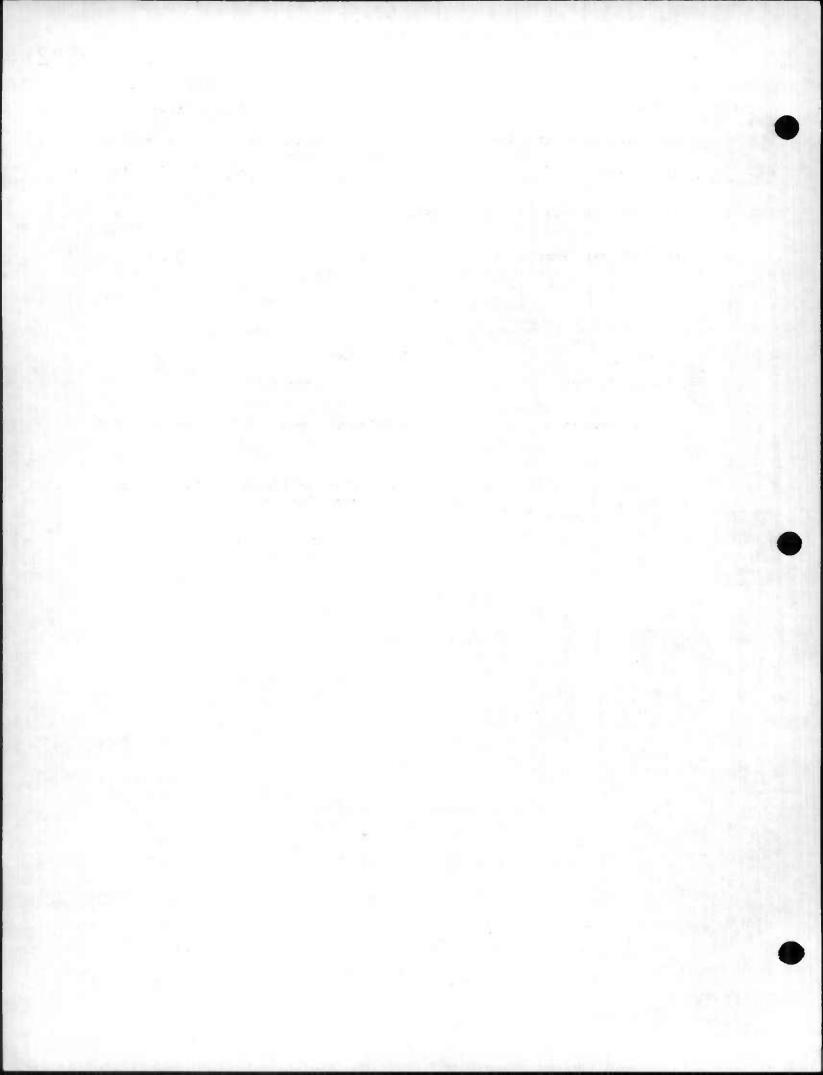
↑₹□ Yes 2 □ No
If Yes, Give
Yeer or Dete⊵946-1951 Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. "natural", or itan filed within 72 hours efter 1 Never Married 2 KMarried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. 11 Woodworker Lumber 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be remained of regard and Mental I Mannie D. Ford Susie Lillian Crosby 19e. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) It of Higher's | Landin 27 is or other tra Mary Ford/wife 681 Fairhaven Road, Dunkirk, Maryland 20754 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important it any injury or 4 Donetion 5 Other (Specify) Ronald S. Wade, 22. Name and Address of Fecility
State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 Baltimore, Maryland 21201

2.1a Faut 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shirts, or heart failure. List only one cause on each line. ntervel Between Onset end Death **Physician** /Medicai Immediate Cause (Final 700 disease or condition resulting in deeth) Examiner The law requires that the death cartificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): detached for use Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Records, þ director, page 2 should be 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? certificate hes 1 Yes 2 No 1 Yes 2 No of Vital or Attending Physicien: Be 25. Wes case referred to medical 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 NO 1 Yes Medical Certification: To 2 ER/Outpetient 3 DOA After this illed in by the funeral 27. Manne of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Division 5 Pending investigation 1 Natural 2 Accident s after deeth 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 1 Certifying Physicias: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) end menner as steted.
2 Medical Examiner On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end manner steted. 29a. Certifier To the within 2 29b. Signeture end title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 1717 30. Name end address of person ed cause of deeth (Item 23a) (Type, Print) Are Just 121 Annapolis 600K 11 12 Registrar's Signeture 31. Date filed (Month, Dey, Yeer)

Registrar **DHMH 16 Rev 6/95** 

State

OCT 09 1997



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State of Maryland / Department of Health and Mental Hygiene

30583

							Cei	tificat	e of	Death			Reg. I	No.			
Physic /Medi		1. Decedent's Neme (First, Frederick		ast)								2. Dete of D Month Sept.		о <sub>еу</sub> 1997	Year		of Death
Examin		4e. Fecility Neme (If not ins Prince Geor									own, or L	ocation of Dec	oth	4c. County Hyat	of Deeth	le.	
Funeral Director		5. Sociel Security Number 213-40-751	9	Sex 1□M 2□F	7. Age (In	yrs. last b	virthdey) Yrs.	If Under Months			24 Hrs. Min.	8. Date of B (Month, I	irth Dey, Yea	ar) .939	9. Birthp Cour S . C	piece (State htry) Carol:	e o <i>r Foreig</i> n ina
Maryland H show fled as	tor	Usuel Residence of Deced 10a. Stete 10b. C Maryland Hy	ounty	ville	10	c. City, To									1		City Limits
with the M 3a or 28a-f	Il Director	10e. Street end Number 5902 Lockwo	ood R	oad				10f. Zip	Code 785					Citizen of		ntry?	
d 2 should be filed within 72 hours after death with the Maryland d 2 should be filed within 72 hours after death with the Maryland file and Mental Hygiene.  7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Maccal Enaminer must be notified at	by Funeral	11. Meritel Stetus  1 Never Merried 2  3 Widowed 4 Dh		12. Wes Dec Armed Fo 1  Yes If Yes, Gi Year or D	orces? 2 ☑ No ve	in U,S.	1	Ves Deced Yes, spec	cify Cub	oan, Mexicai	n, Puerto	ecify Yes or N Rican, etc.)	lo-		ce - Americ ck, White, v: wh		
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emil. Pages 1 and Pagestreet of Health moortant: if item 27 my injury or other tr		20a. Method of Disposition 1 ☐ Buriel 2 ☐ Crem 4 ☐ Donetion 5 🖾 Ot	etion 3 [ her (Spec	Removei from	Stete	Ob. Pieca cemet	of Dispo e <i>ry, cre</i> n	sition (Nen netory or o	ne of ther ple	ece)	i	Dete	20c.	Location -	City or To	own, Stete	
Demit. Depart Import any inj		21. Signature of Funerel S Joseph	Prvice Lice Va	n Sant	1	_						rd, 655 nd 2120		Balt	imor	e Str	eet
Physician /Medical Examiner	Examiner	23a. Part Enter the dises shock, or heert feilure immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, jeeding to immediate	. List only	eb.	Pn.	to (or as e	conseq	uence of):					errest.			Approxin Interval E Onset sr	Between
e death certificate be execu-	Physician/Medical E	Sequentially list conditions if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	L	d	Due	to (or es e	conseq	uence of):		iven in Pert I			i tobac	co use co	ntributs to	the caus	e of death?
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To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	29e. Certifier 1 Ce (Check only 2 Ms	rtifying Pi dical Exa	hysicism: To the miner: On the bu end men	best of my asis of exa- ner steted.	knowledg minetion e	e, deeth	occurred a estigetion,	at the ti	ime, dete en opinion, dee	d pleca, th occur	snd due to the	e cause o, date e	(s) and ma	anner as st and due to	teted.	e(s)
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State of Maryland / Department of Health and Mental Hygiene

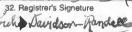
Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth OCTOBER **Physician** MARGARET GASIOR 6, 1997 9:45 PM /Medical 4e. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BAY VIEW MED. CENTER BALTIMORE USA Hours Min. 8. Date of Birth (Month, Dey, 6-5-09 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** 1□M 2□F MARYLAND 215-07-6819 Yrs. 88 Director Usuel Residence of Dacadent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 743 S. CURLEY STREET 238 21224 USA Funerai 72 hours efter death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: or items Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify ₩idowed 4 Divorced "natural". WHITE Completed Decedant's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use ratired) permy Pages 1 and 2 should be filled within 72 infrontant: If them 27 is marked other than "nettuenge once. 15. Dacedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) 8 YEARS Collega (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be JOHN STACHAROWSKI MARY JANKOWIAK 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MS. LORRAINE GASIOR 1950 STEVENS DR. EDGEWOOD MARYLAND 21040 20a. Method of Disposition

1 Buriel 2 Cremation 3 Removel from State 20b. Place of Disposition (Neme of cemetery, crematory or other piece) 20c. Location - City or Town, State STANISLAUS CEMETERY 10-10 BALTO. MD. 4 ☐ Donetion 5 ☐ Other (Specify) e of Funeral Service Licensee KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE BALT application, that caused the death. Do not antar that mode of dying, such as cerdiac or raspiratory arrest, rona cause on each line. DUNDALK AVENUEBALTIMORE, MD. Pert1. Enter the disease, or comshock, or heert feilure. List only Approximate Intervel Between Onset end Death Physician CARDIO RESPIRATORY ARREST

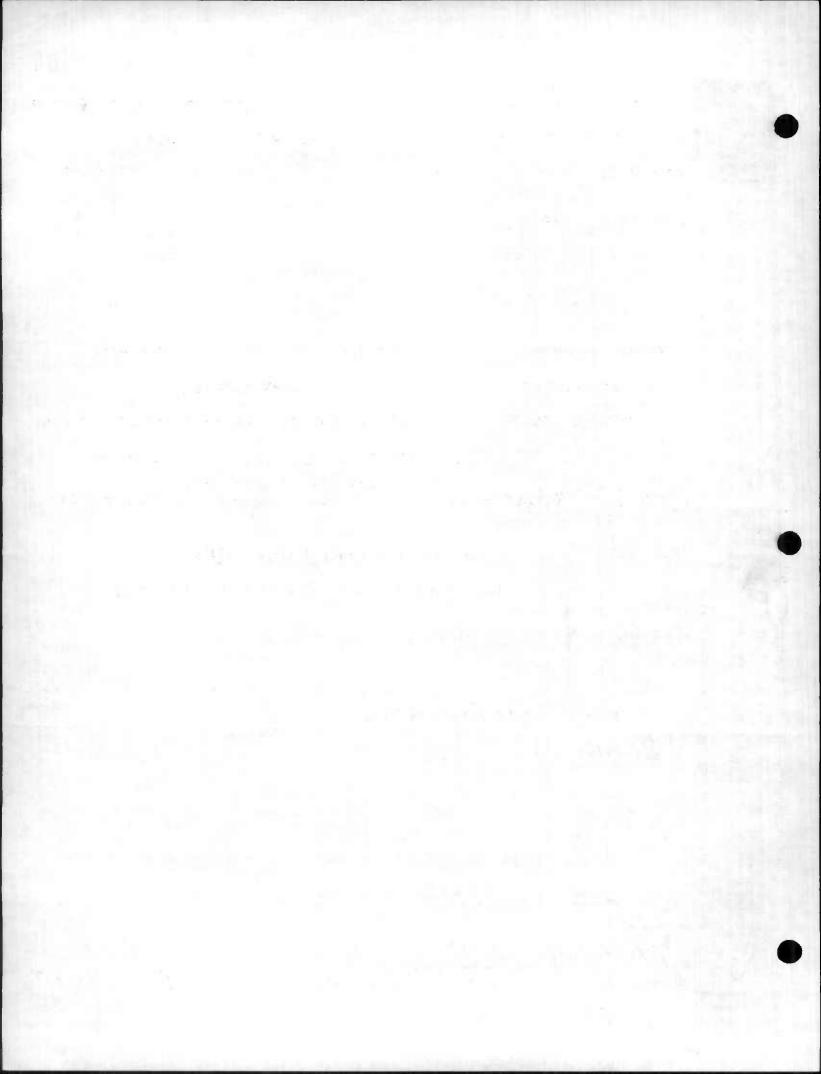
Dua to (or as a consequence of): /Medical Immediete Ceuse (Finel disaasa or condition rasulting in deeth) Examiner METASTATIC CANCER OF BREAST Examiner Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseesa or Injury that initieted events resulting in death) Lest Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es a consequence of): The law requires that the death certificete Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death2 FIBRILCARIM 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No q 24b. Ware autopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Was an autopsy DIARBIUS certificate 1 Yes 2 TWO 1 Yes 2 No or Attending Physician: Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) M No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 1 Inpatient 2 DER/Outpetient 3 DOA this 27. Manner of Deeth 28e. Deta of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Neturel Injury deeth. 1 ☐ Yes 2 ☐ No 2 Accidant efter deeth Director: In by the 3 Suicide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide the Hospital within 24 hours e Tertifying Physiclen: To the bast of my knowledge, death occurred at the time, deta end plece, and due to the causa(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end plece, and due to the causa(s) end menner steted. edicai 29a. Certifier completely (Check only 29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number NOI 30. Name and address of person who completed ceuse of deeth (Itam 23e) (Type, Print) BANK STREET BALTO MUZIZZA THUNGAMMA

State Registrar 31. Date filed (Month, Day, Year) DCT 0 9 1997



**DHMH 16 Rev 6/95** 

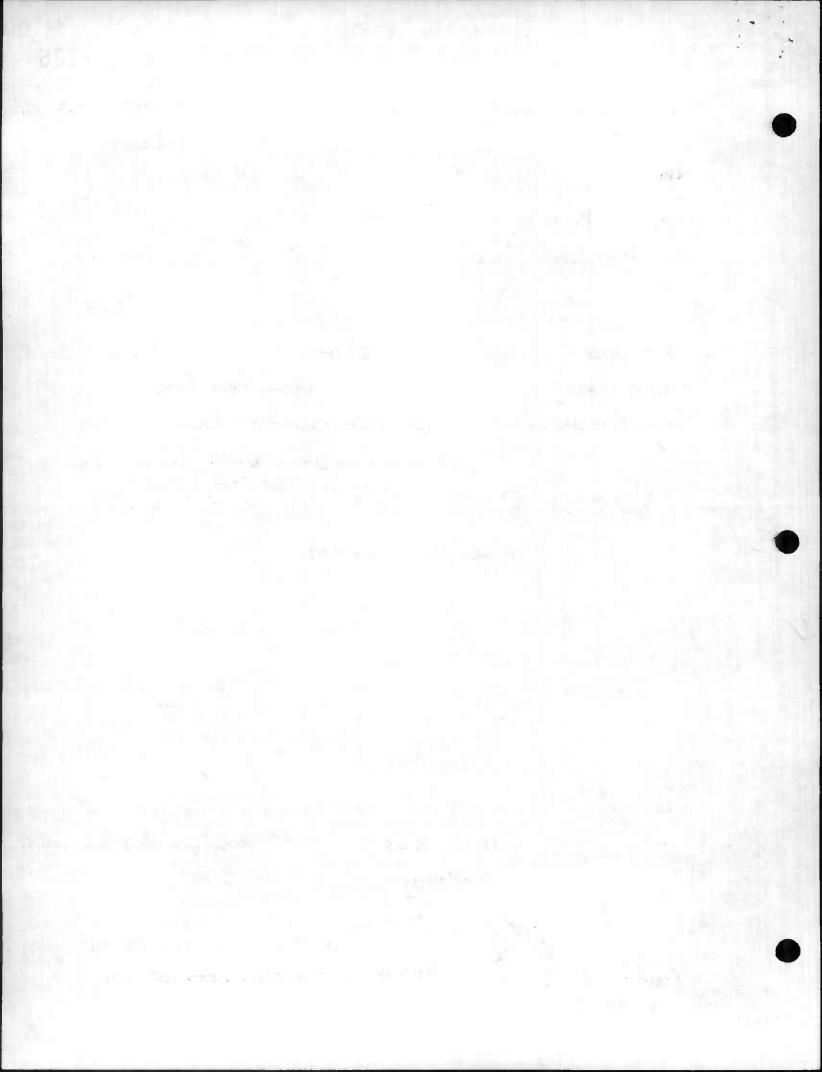


WRC . 97-5541-021 ERRON THOMAS

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State of Maryland / Department of Health and Mental Hygiene 97 30585

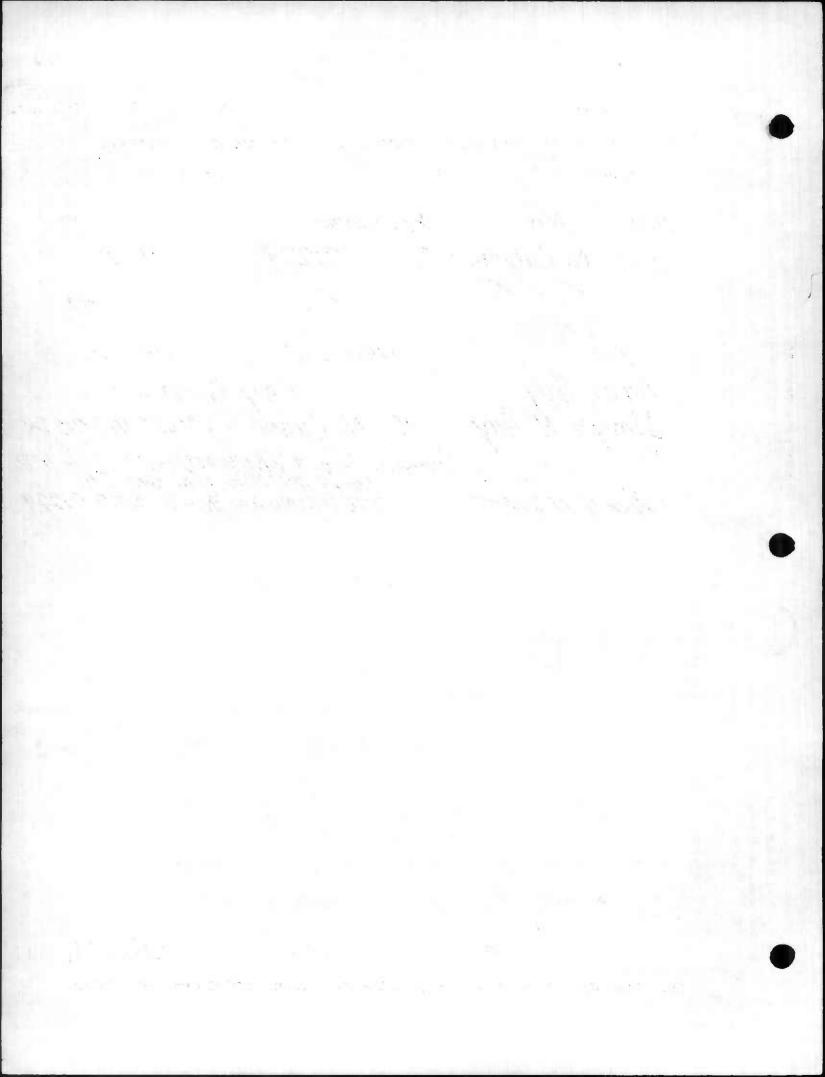
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	2		30. Name end eddress of person who	completed cause of de	eeth (Item 23e)	(Type, Print) Penn S	tree	t. Balt	imore, M	arvland	21201	
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State of Maryland / Department of Health and Mental Hygiene 97 30586

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WRC 97-5684-510 **GLORIA** 

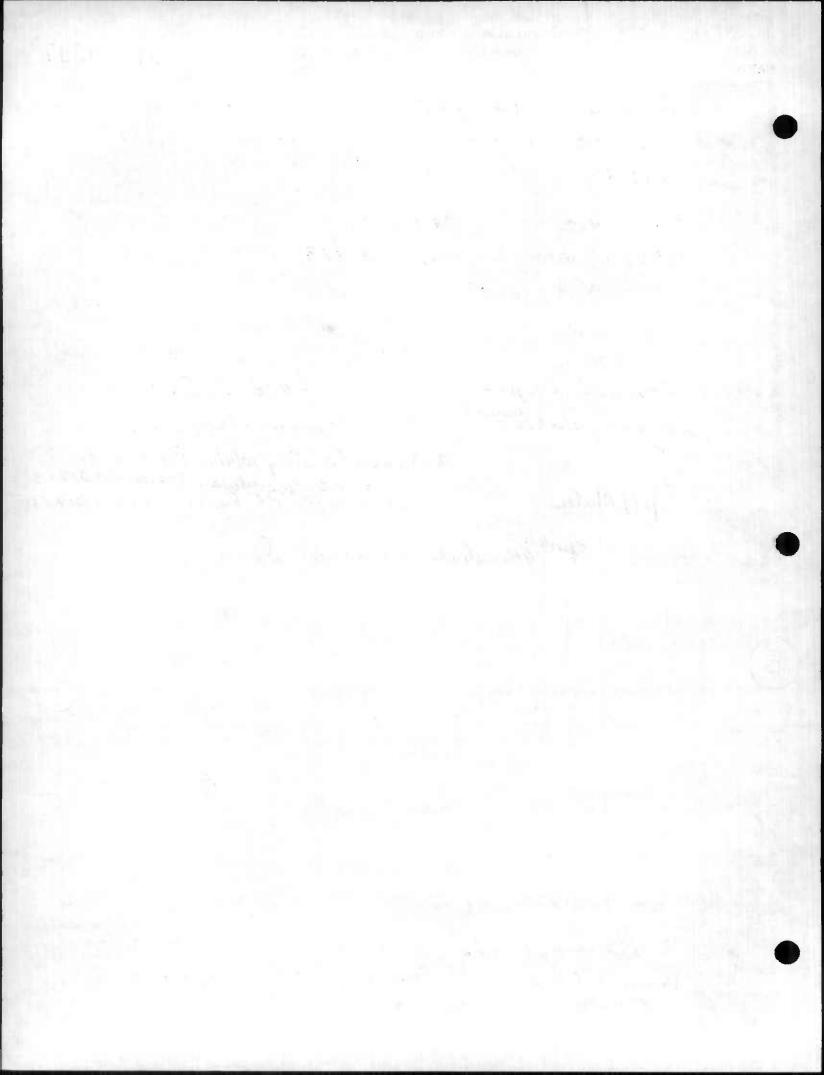
#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 7

HARPER Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Death Month **Physician** ITAR 05, 1997 OCT. 12:34 PM. /Medicai 4a. Facility Name (If not Institution, give straat end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1642 N. WASHINGTON STREET BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) **Funeral** 10 M 20 F Days Min 214-44-7256 Usual Residence of Decedent 50 Yrs. Director 10a State 10b. County 10c. City, Town or Location a or 28a-f show to notified at 10d. Inside City Limits 1 Ves 2 □ No Director 10e. Street and Number 10g. Citizen of Whet Country? 1 N G Fair Stru 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 W No If Yes, Give Нете 23а 1642N. Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - American Indian 11. Marital Status "natural", or item Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify Specify: Completed by BLACK 3 Widowed 4 Divorcad 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ulth and Mental Hygiene. 27 Is marked other than "r r treumatic event, the Wed Elementary/Secondery (0-12) Coilege (1-4or 5+) KEE Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) Be Peges 1 and 2 should be nent of Health and Mental SAMUEL 0 19a. informent's Name/Relationship (Type, 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1542 N BROADWAY LEONARD HARPER BALto. Md. 21213
Date 20c. Location - City or Town, State 27 or other t 20b. Place of Disposition (Neme of cemetery, cremetory or other) 20e. Method of Disposition Date etery 10/9/97 BALTON d.
of Facility OBd WAY BACTO. Md 21213 1 Burial 2 Cremation 3 Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licansee P.C. FUNERAL HOMEL SERVICE Part i. Enter the disease, or complications that caused the death. Do not antar the mode of shock, or heart failure. List only one ceuse on each line. Approximate Intervat Between **Physician** immediate Cause (Final disaase or condition resulting in death) **Examiner** Examiner be executed and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): 60, Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0 signed by t 1 Yes 2 No 3 □ Probably Unknown þ Records, 24b. Were eutopsy findings available prior to completion of cause of death? Completed page 2 should 24a. Wes en eutopsy Yes 2 No 12 Yes certificate Division of Vital Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Rasidence 6 Other (Specify) 1 X Yes 2 □ No Certification: To 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred After 1 Delatural 2 Accident 5 Pending Invastigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the ceuse(s) and menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier 94 29b. Signature audittle of certifier 29c. License number 29d. Date signed (Month, Dev. Year) O.C.M.E. OCT. 06, 1997 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

State Registrar Chute, no 111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene

29d. Date signed (Month, Day, Year) OCTOBER 04 1997

30588

DALE L.HYRE

Certificate of Death

2. Date of Death

Physician
/Medicai
Examiner

1. Decedent's Name (First, Middle, Last)

3. Time of Death

**Funeral** 

Director

"natural", or items 23e or 28a-f show edical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Introcrant: if item 27 is merked other than "natural", or ite any Injury or other treumatic event, tre Medical Example and Baltimore, Maryland 21215-0020

Physician **Examiner** 

Division of Vital Records, P.O.

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director,

4a. Facility Name											OCTOBI	ER	04 19	997	12:25	5 AM
	(If not institution	on, give st	treet end nur	mber)				4b. City	Town,	or Lo	cation of Dear	th	4c. Coun	ty of Death		-
WASHING	TON COU	UNTY	HOSPI'	TAL				HAC	ERS	TOV	VIN		WASH:	INGTO	N	
5. Social Security 232-84-1		6. Sex	M 2 F	7. Age (In ) 44			In r 1 Y nths Day		der 24 I rs N	Hrs. /lin.	8. Dete of Bi (Month, D. OCT.	gh, Y	952	9. Birth Cqu West	plece (State o	r <i>Foreig</i> nia
Usuel Residence																
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W.Va	Buck	hann	on		Buckh	nannon									1 🗆 Yes	2 L/3 No
10e. Street end Nu						10	f. Zip Code					10g.	Citizen of	What Cou	intry?	
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17. Fether's Name Arthu	(First, Middle ur Will		Hyre					18. M	ther's	Name 1ae	(First, Middle Cutri	ght	den Suma	me)		
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21. Signature of F	11		9				_	asne	Shy I	un	eral H	ome	, In	c.		
						736	Edmon	son .	Ave.	. , C	atonsv	ill	e, M	d. 21	.228	
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29c. License number

O.C.M.E.

State Registrar

31. Dete filed (Month, Day, Year) OCT 0 9 1997

29b. Signeture end title of certifier

Dand

111 Penn Street, Baltimore, Maryland 21201

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Rebecca В. Harris September 26, 1997 7:22 am /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Elder Care Homewood Baltimore County **Baltimore** Hours Min. 8. Data of Birth (Month, Day, Year)
Nov. 3,1904 7. Age (In yrs. last birthday) If Under 1 Yaar 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 217-30-2737 1□M 2√2 F 92 unknown Director Usual Residence of Decedent 6000 yland 10b. County 10a State the Marylan 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f shor the Medical Examiner must be notified at 1 ☐ Yas 2€ No Director Baltimore Baltimore County 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6000 Dellona Avenue 21212 U.S.A. Funeral 11. Marital Status unknown 12. Was Decedent Evar In U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Raca - American Indian. Black, Whita, atc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation 18b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) Coilege (1-4or 5+) unknown Homemaker Someone elses home unknown 17. Fathar's Nama (First, Middle, Last) 18 Mothar's Nama (First Middle Maidan Sumame) 3e 12 should be financial be in marked of Charles Harris Lillie Holland 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Electh and Important: If them 27 is m any Injury or other traum Spice. 401 E. 25th Street #2B, Baltimore, Maryland 21218 Etlow Echols/cousin 20b. Piece of Disposition (Name of cematery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☑ Othar (Specify) 21. Signatura of Funarai Service Licensee Joseph B. Van <sup>22</sup> Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street Sant Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart tailure. List only one cause on each line. Approximate tnterval Between Onsat and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and and physician the burial Box 68760. Physician/Medical Due to (or as a consequence of) attending Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 d signed by d 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, P. à 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed peen Ħ page 2 1 Yas 2 No certificate 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 25 No Be 28. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Deursing Home 5 Residence 6 Other (Specify) 2 報 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 28d. Describe how injury occurred Alber Attending 183Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) after A 4 I Homicide To the Hospital o within 24 hours at To the Funeral Di completely tilled is Technifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

Image: Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 30. Neme and address of person who completed ceuse of deeth (item 23a) (Type, Print) 3007 E. Northern Parkway Boultimore, MD Ziad K. Mirza, M.D

State Registrar 31. Date filed (Month, Day, Year)

OCT 09 1997

-32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 97 30590

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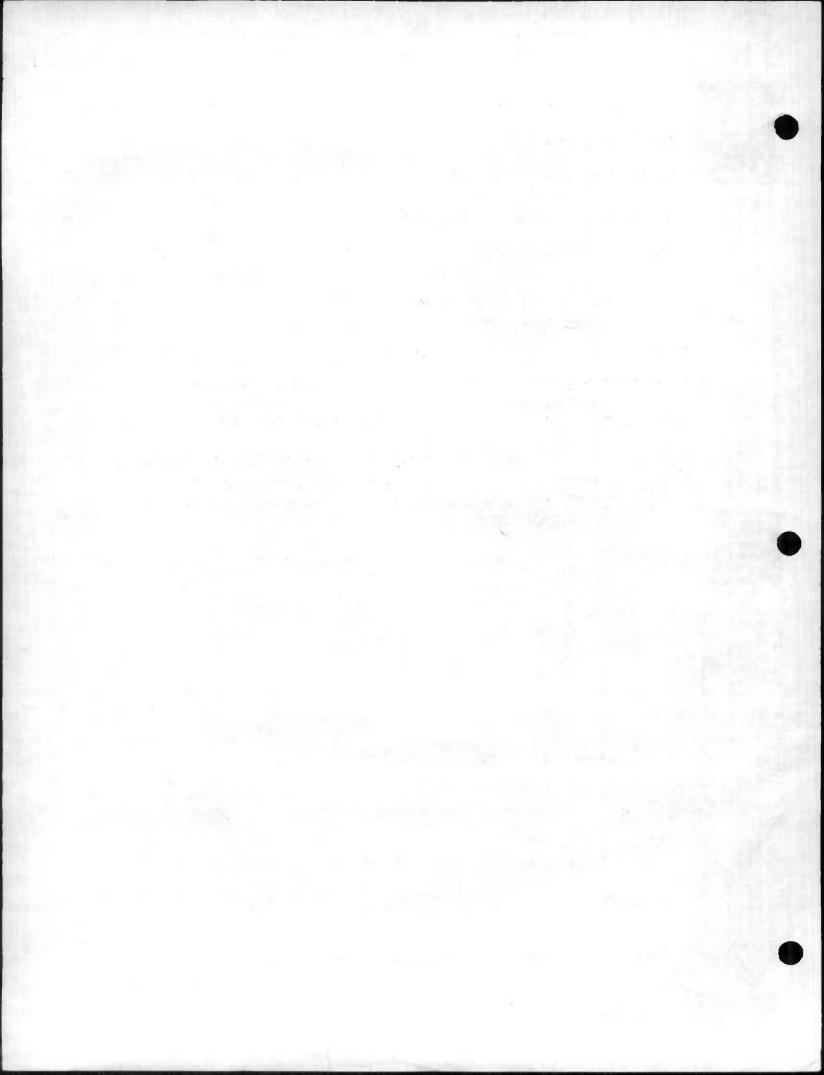
State of Maryland / Department of Health and Mental Hygiene

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	-	10e. State 10b. County		10c. C	City, Town or Lo	ocation							10	d. Inside	City Limit
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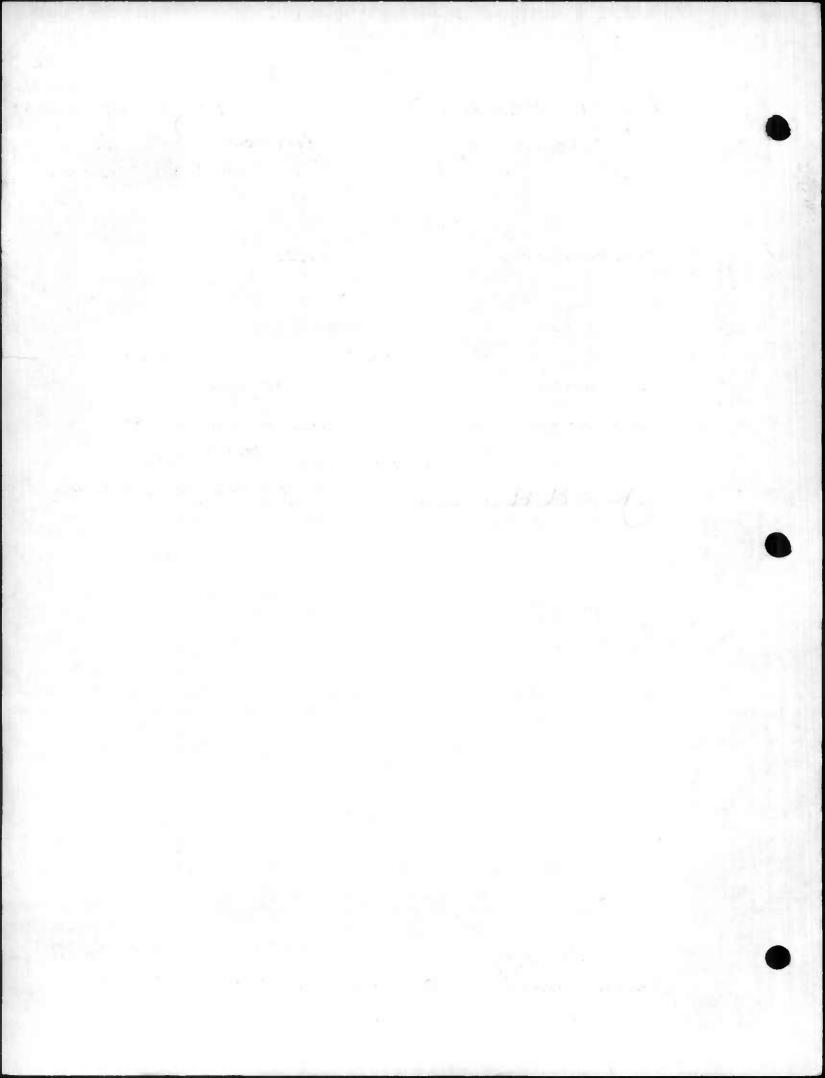
DHMH 16 Rev 6/95



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 7

		Decedant's Name (First, Middle,	Last)		Cer	tificate	of L	Death	2. Date of D	Reg. No.		3. Time of Deeth
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ild be file lental Hyy ked othe ic event,	o Be	Samuel Reynol							Turner	,		
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and 2 selith and 2 selith and 27 is		Edward M. Imbro		าท				nue, Bal			1225	
产工		20e. Method of Disposition		20b. F	Pleca of Dispos	sition (Nem	a of	Sh I	Dete	20c. Location		wn, State
		1 Suriai 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Othar (Spe		ite	udon Pa			1	0/7/97	Baltir	nore.	Md.
permit. Page Department of Important: If it any injury or otice.		21. Signeture of Funerel Sarvice Lie	ansee		Ga Ga	Nama and	Addres Kaı	s of Fecility ufman Fu		ome at 1	Meadow	ridge MP
Physician		23e. Part 1. Enjer the diseese, or co shock, a heert feiliura. List or	implications that causely one cause on eecl	sed the deet h lina.	h. Do not ente	or the mode	of dying	ngton Bl g, such es cardis	c or respiratory	Criage, arrest,	MO.	21075 Approximate Intervsl Between Onset and Death
/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in deeth)	e. RENA				Υ,	ACUTE	OVER	CHRON	ic	6 MONTH
HALLER	niner		GAST		CARCIA			PROBABO	V REC	UPPE	1	14 MONTH
F	al Exami	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury	ь		or es e consequ	P	)	TILVONIO	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	DIOCER		
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that the de ad by the detached	Physician/M					ioanymig oa	300 g.··			Yes 250 No		pably 4 Unknown
law requires that the death cert es been signed by the attendin 2 should be detached lor use	Completed by									s an autopsy ormed?	SVS	ere sutopsy findings ilsble prior to appletion of cause death?
The late he	E O								10	Yes 2 No	10	Yes 2 No
ilclen: The lav certificate hes rector, pege 2	Bec	25. Was case referred to medical						28. Plece of De	eth (Check only	one)		
	To	examiner? 1 □ Yas 2 ☑ No	Hospitel: 1 🗷 Inpe	atient 2	ER/Outpatien	3 DO	Othe	er: 4 Nursing H	doma 5□Ras	idanca 6 🗆 Ot	her (Specify	)
il or Attending Phy s efter death. I Director: After this d in by the funeral d	Certification:	27. Menner of Desth  1 Neturel 5 Pending 2 Accident Investiget	ion	njury Dey Year)	28b. Tima of Injury	M 28	C. Injury Work	st :? Yes 2 No	28d. Describe	how injury occu	rred	
al or Atte s eftar de il Directo ed in by ti	Sertific	3 Suicide 8 Could not 4 Homicide determine		Injury - At he etc. (Specif	ome, ferm, stre	et, fectory,	office			(Street and Num wn, Stete)	ber or Rura	Route Number,
To the Hospital or Atwithin 24 hours efter of To the Funeral Direct completely filled in by	edicai (		Physicisn: To the beaminer; On the basis	of examine								
within 2 To the	M	29b. Signatura end title of pertiler		1		29c.	Licanse	number		29d. Dete sign	ed (Month, I	Dey, Year)
->-0		(.10	uam/				500	52200	0	OCTOB	ER 3	, 1997
4		30. Name and address of person wh	o completed cause o	-	23e) (Type, I			r. BAL				
Sta	te	31. Dete filed (Month, Dey, Year)	32. Regi	strer's Signe	etura		, ,	- 0/10		1 3		
Registr		OCT 0 9 19	17 4	ia Daine	son-Rango	L. 00-						

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth JOHNSON HESTERFIELD October 21:34 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Daath ECOUR 171mores If Undar 1 Year If Undar 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth Month, Dev. Y FL, B, 12M 2□ F Days Months Hours Yrs. 10b. County 10c. City, Town or Location 10f. Zip Code 10g. Citizen of Whet Country? 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detas: 1 Yes 2 No Specify: Specify: Plack 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be file Department of Haelth and Mental Hy-Amportam: If Nem 27 Is marked other any linjury or other treumstic event size.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

should be filed within 72 hours after and Mental Hygiana.

within 24 h To the Fur complately

<i>)</i>	Phy /N Ex	ysician ledical aminei	
Division of Vital Records, P.O. Box 68/60,	septal or Attanding Physician: Tha law requires that the common rificata be executed hours after death	nerel Director: Aftar this certificata has been signed by the attending physician and y filled in by the funarial director, paga 2 should be delibered for the as the burial-transit	al Certification: To Be Completed by Physician/Medical Examiner

5. Social Security Number 9. Birthplece (State or Foreign — Country) 213-16-5255 Usuel Residance of Decedent 10e State 10d. Inside City Limits 1 HYes 2 No Director 10e. Street end Number Funeral 11. Maritel Stetus 1 Never Married 2 Married by 3 1 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Majden Be HARLIE VO 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Neme of cemetery, cremetory or other place thod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Gremetion 3 ☐ Removel from State 4 ☐ Donetion /5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses hase, the complications that caused the death. Do not enter the mode of the List only one cause on each line. Approximete Interval Between Onset end Death Immediate Ceuse (Final diseese or condition resulting in deeth) Sequantially list conditions, if any, leeding to immediata cause. Enter Underlying Couse (Diseese or Injury that Initiated events resulting in death) Lest Dua to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of ceusa of deeth? 24a. Wes en eutopsy performed? 1 Yes 1 Yes 2 No 25. Wes cese referred to medical 26. Piece of Deeth (Check only one) etaminer? Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 2□ No 1 ☐ Inpatiant 2 ☐ R/Outpatient 3 ☐ DOA 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, and due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the tima, dete end piece, and due to the ceuse(s) end menner steted. 29a. Certifier (Check only one) Medic

29c. License number

29d. Date signed (Month, Day, Year)

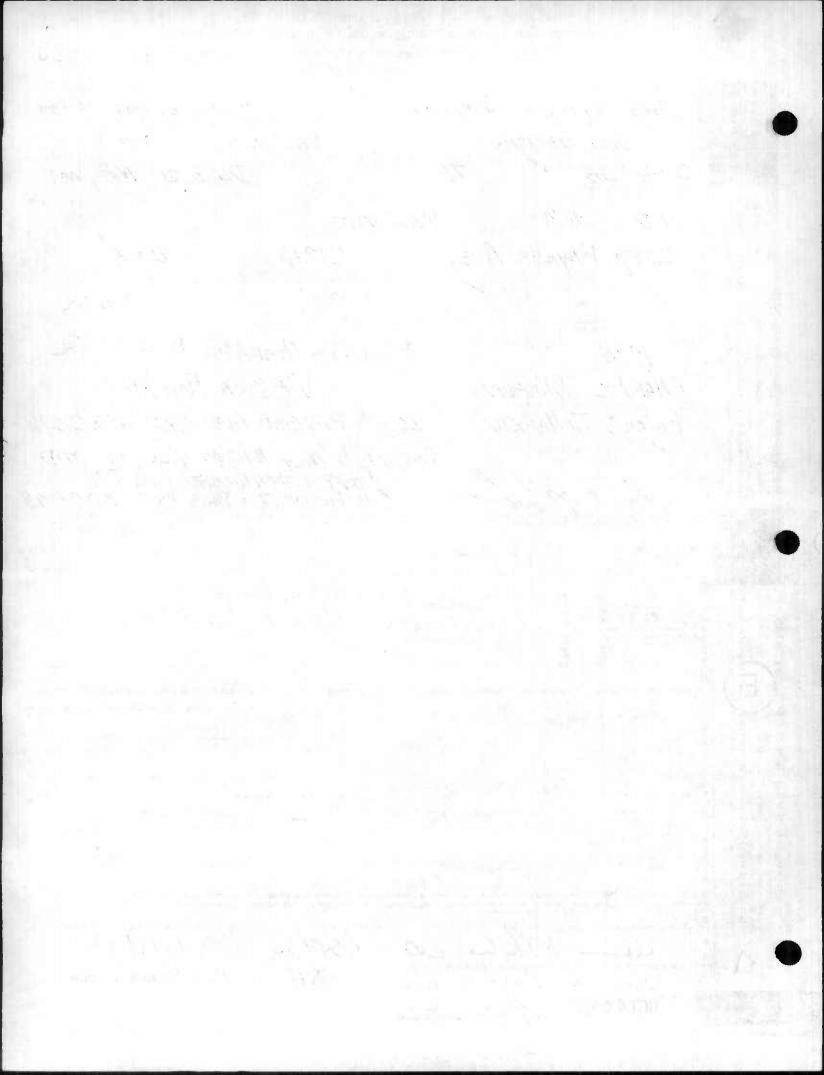
State Registrar 29b. Signeture and title of certifier

30. Nemeand eddress of person who completed cause of deeth (Item 23a) (Type, Print)

ARKES

who Devide

Registrer's Signeture



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** James uner Gitcher /Medical 4a. Facility Name (If not Institution, give street end number) 4c. County of Deet 4b. City, Town, or Location of Death Examiner 5. Social Security Number 212-36-9618 Date of Birth Randell If Under 24 Hrs. 8 1/35/3 Balzom Dir Wit 7 Age (In yrs. lest birthday) 58 Yrs. If Under 1 Year 9. Birthplace (State or Foreign Balles), Md. 6. Sex 1 M 2 F Days 10a. State Md. 10c. City, Town or Location Catonsville 10b. County Baltimore 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 21228 10g. Citizen of Whet Country? U.S.A. Overbrook Road Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1∑ Yes 2□ No If Yes, Give Nat. Guard Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. . Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: by Specify: White 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Collage (1-4or 5+) Elementary/Secondary (0-12) Social Insurance Specialist S.S.A. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Otto Kunert Marie Buhl 19e. Informant's Name/Relationship (Type, Print) Lucy M. Kunert/Wife 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 25 Overbrook Rd., Catonsville, Md. 21228 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) Chesapeake Crematory 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 □ Burlal 2 ☐ Cremation 3 □ Removel from Stete 10-10-97 Beltsville, Md. 5 Other (Specify) Fungal Sprice Livenses 22. Name end Address of Facility Sterling-Ashton Funeral Home, Inc. 736 Edmonson Ave., Balto., Md. 21228 noissale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, reflure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting In death) Lest Physician/Medical Due to (or as e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by Completed 24e. Wes an autopsy 24b. Were autopsy findings aveileble prior to completion of cause of death? 1 ☐ Yes 2 No Be 25. Wes case referred to medical exeminer? 28. Place of Death (Check only one) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Cartifying Phyeician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) end manner as stated. 2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) end manner stated. Medical (Check only one)

Examiner Division of Vital Records, P.O. ed by Physician: this After Attending deeth within 24 hours efter deet To the Funeral Director: 2 20 0

**Funeral** 

Director

ms 23a or 28a-f show

Items 2

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I Hygiene.

permit. Peges 1-afid 2 should be filed w Department of Health and Mental Hygies Important: If item 27 is marked other th any Injury or other traumatic event, the once.

**Physician** /Medicai

Baltimore, Maryland

filed within 72 hours efter 21215-0020

> State Registrar

**DHMH 16 Ray 6/95** 

29b. Signeture and title of cartifier

31. Date filed (Month, Dey, Year) July Davidson-Randall OCT 0 9 1997 ISTVA

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) - CID 4 West 32. Registrer's Signature

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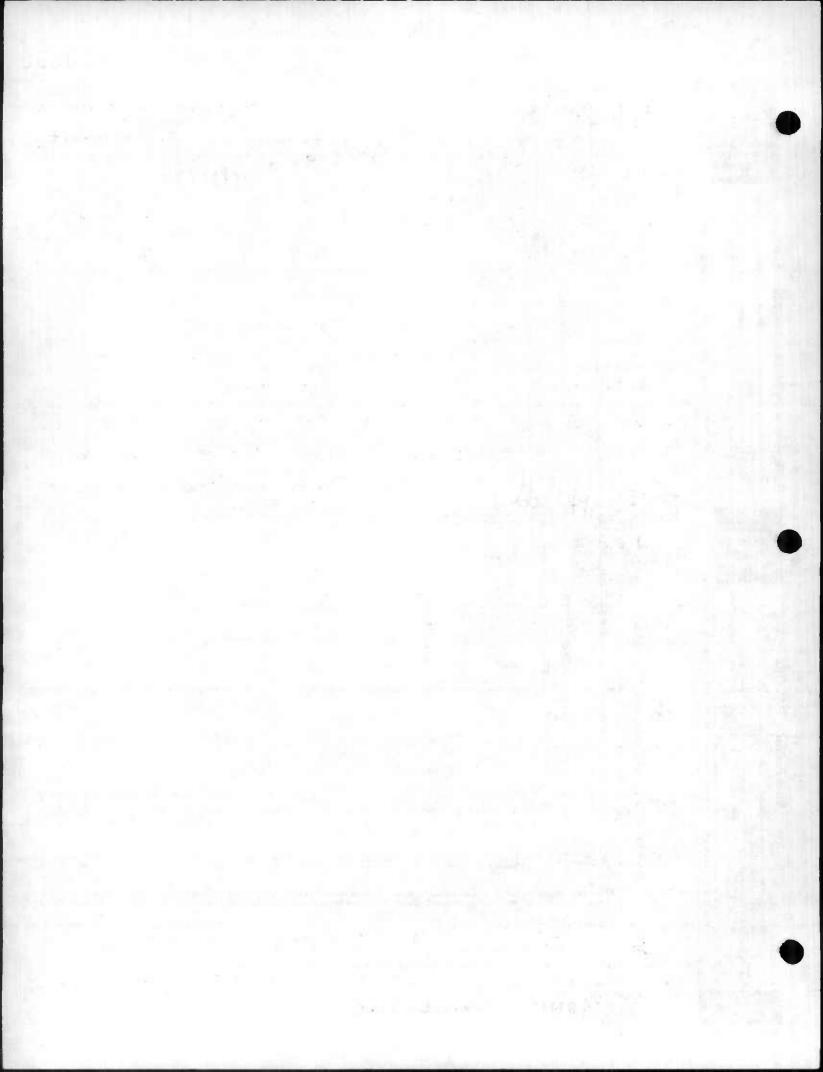
State of Maryland / Department of Health and Mental Hygiene

30595 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Ida September Kurtz 15 1997 10:05 Am /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Conty Daltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) , Funerai 10 M 219 F 225-30-9955 70 Yrs. Director Usual Residence of Decedent deeth with the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Funeral Director 1 Yes 2 No Md. N/A Baltimore 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? Items 23a or 334 S. Calhoun St. 21223 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or he any injury or other traumatic event, the Medical Examina any injury or other traumatic event, the Medical Examina and injury or other traumatic event, the Medical Examina and injury or other traumatic event, the Medical Examina and injury or other traumatic event. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by white 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6 Glass Cutter Columbia Glass 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Will Gullett 2 Anna Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 334 S. Calhoun St., Baltimore, Md. Jim Kurtz - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9/17/97 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery Baltimore, Md. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Meadowridge MP 7250 Washington Blvd., Flkridge, Md. or complications that caused the List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai fmmediate Cause (Final Em Physemo 10 yrs disease or condition resulting in deeth) **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed ettending physician end for use as the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that higherd events. Due to (or as a consequence of): Records, P.O. Box 68760, that Initieted events resulting In death) Last Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t per tension þ 24b. Were autopsy findings available prior to completion of cause of death? Certification: To Be Completed 24e. Was an autopsy performed? peen os teo porosis pege 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate funeral director, peg Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Stella Mars 22 mercy 1 Yes 2 No Other: 4 | Nursing Home 5 | Residence 6 Nother (Specify) HOSPICC 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation within 24 hours efter death.

To the Funeral Director: Af
completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edicai 29a. Certifier (Check only ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50847 9/15 Leci 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8-Sony N. Calvert 315 21205 31. Date filed (Month, Day) 32. Regisfare Signature

Funda Daydon-Randall State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Daath 3. Tima of Death **Physician** KOWALCHUK 10:35 P.M Detober HENRY /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner CARAWAY eisterstown BALTINORE COUNT Under 24 Hrs. 8. Data of Birth (Month, Dey, Yeer) A Say 7. Aga (In yrs. lest birthday) if Under 1 Year 5. Social Security Number 9. Birthplaca (State or Foreign Country) **Funeral** Days 1XM 2□ F Director 218-22-6055 Usual Rasidance of Dacedant 10a. Stata 10c. City, Town or Location 10d. inside City Limits must be notified at 1 ☐ Yes 2 ☑ No Directo 10e. Stre 10g. Citizan of What Country? U.S. Funeral Was Decadant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 12. Was Dacedent Ever in U.S. Armed Forces? 1 Never Married 2 Married If Yas, Giva Yaar or Dates: WW TI 1 ☐ Yas 2 ☑No White þ 3 Widowad 4 Divorced Completed 15. Dacedant's Education 18e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Sacondary (0-12) College (1-4or 5+) TRANSPORTATION Mechanic Baltimore, Maryland permit Petpes 1 end 2 should be in Organization of Health and Mental Hy Illinourant in Health 27 is marked any injury or meter 27 is marked and injury or meter 27 is marked 27 is marked 27 is marked 27 is marked 27 is marked 27 is marked 27 is marked 27 is marked 27 is marked 27 is marked 27 is marked 27 is marked 27 is marked 27 is marked 27 is marked 27 is ma 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be OWALCHUK ANIEL 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip H. ZAPPARDINO-SISTER SONJA E. PRAH Street BAHO MA 3022 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Metro REMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Fureral Sarvice Licensea 22. Name end Addrass of Fecility Charlton Funeral Home 2007 Eastern Avenue Baltimore, Maryland 21231 curve ation, that caused tha daath. Do not antar tha mode of dying, such as cerdiac or raspiretory arrast, one cause on aech lina. Approximate Interval Batween Onset and Death **Physician** Rectal AdenocARLINOTA immediata Causa (Final disease or condition resulting in death) **Examiner** Physician/Medical Examiner Sequentially list conditions, if any, leading to Immadlete ceuse. Enter Undarlying Ceusa (Disease or Injury that Initiated events rasulting in daeth) Lest Dua to (or as a consequence of): the Dua to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 8 24b. Wara autopsy findings available prior to complation of cause of deeth? Completed 24a. Was an autopsy performed? certificate 1 Yas 2 No director, Be 25. Wes case rafarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred Medical Certification:

Box 68760 P.O. 1 Records, Division of Vital After this To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral

Registrar

31. Data filed (Month, Dey, Yeer) 0 9 1997

1 Neture

2 Accidant

3 Suicide

29a. Cartifian

4 Homicida

29b. Signetura and titla of certifier

30. Nema and address of person who completed cause of death (Itam 23a) (Type, Print) MARSHAL

5 Panding invastigation

6 Could not be datarmined

29c. Licansa number

1 Yas 2 No

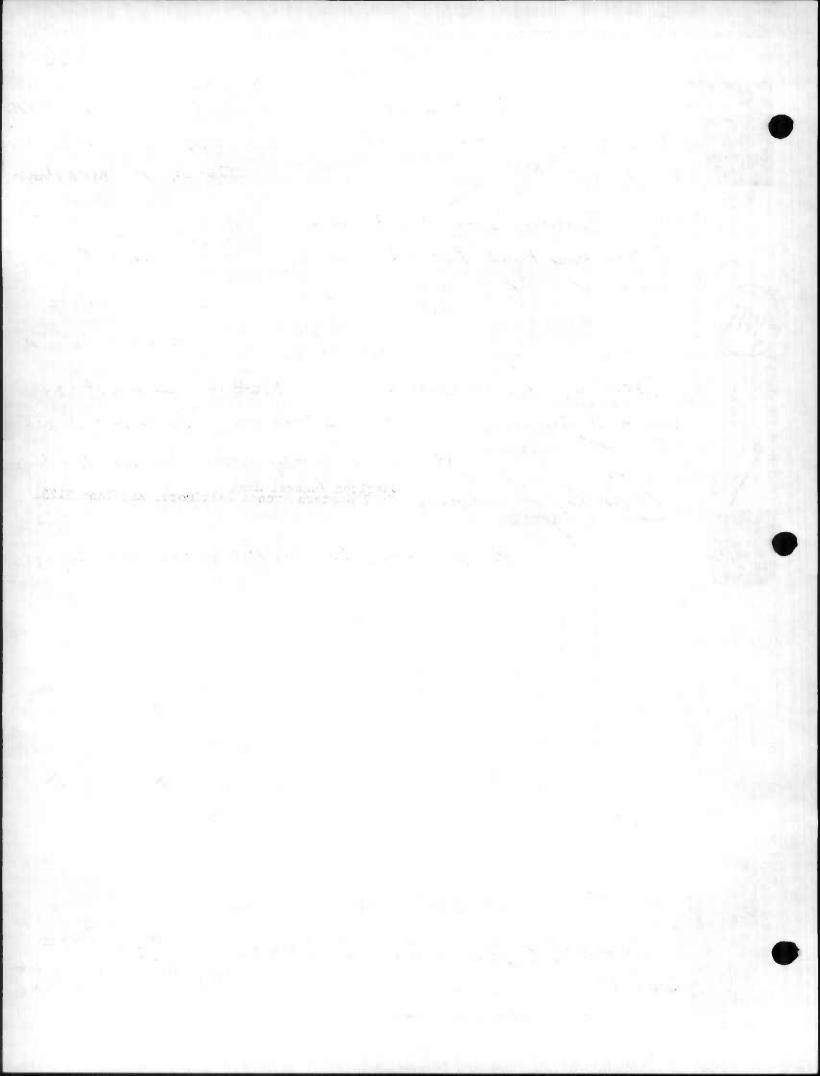
1 Certifying Phyalcian: To the best of my knowledge, death occurred at tha tima, data and plece, and due to tha ceusa(s) and mannar as stated.
2 Madical Examiner: On the basis of axemination and/or invastigetion, in my opinion, daath occurred at the time, date and place, and due to the ceusa(s) and manner statad. 29d. Deta signad (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

306 Levine 4000 Old Court Rd.

32. Registrar's Signature

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)



97-5521-510 AM RAYMOND KUTA Ite **Physician** /Medical Examiner **Funeral** Director the Maryland or 28a-f show must be notified at Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

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		Raymond	Da	vid F	Kuta	ı				Month SEPTI		Day ER 27	Year . 1997	3:22	P
4e. Facility Name (								4b. City, To	own, or L	ocation of Dea		4c. Count			*
2221 L	AKE AV	E.						BALT	IMORE	3		N	/ A		
5. Sociel Security N 219-40-		6. Sex 12 M 2 ☐ F	7. Ag	e (In yrs. las	st birthda Yrs.	Months	Days		Min.	8. Date of B (Month, I	Birth Day, Ye	1945	9. Birth Cou Mar	plece (State of unitry) yland	r Foreign
Usual Residence of									1	CODI	٠,	1,45	Hat	yrana	
MD State	N/A			10c. City,		Location More								10d. Inside Cit	
10e. Street end Nui	mber					10f. Z	p Code				10g.	Citizen of	Whet Cou	intry?	
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11. Marital Status  1 Never Marri 3 Widowed		ried Armed	Forces?	Ever in U,S. No	. 13	3. Was Dece If Yes, spo 1  Yes				ecify Yes or N Ricen, etc.)	10-		ick, White	hite	
(Spec		nt's Education	d)		16a. Dec	cedent's Usi ve kind of w b. DO NOT (	iai Occu	pation during mos	st of work	ina	16b	. Kind of B	Business/I	ndustry	
Elementery/Seco	ndary (0-12)	College	(1-4or 5	i+)		chan		eamar			N	lerch	nant	Marin	nes
17. Father's Name	(First, Middle,	Lest)						18. Moth	er's Nam	e (First, Midd					
Ma	rion	Kuta								Anna	Zyc	ch			
19a. Informent's Na Robert J										a/Route Num 1ston,				ip Code)	
20a. Method of Disp 1 Burial 2 4 Donetion	Cremetion	3 □Removal fro	m State	cen	netery, ci	position (Na rematory or cremat	other pla		10/	Dete 7/97		Location		Town, State	
21. Signeture of Fu	eral service	Mod. Mo	Pr	nald		Crema 299 F:	nd Address	Soci Fick	ety (	of Md. Baltim	, In	nc.	2122	8	
23e. Pert1. Enter the shock, or hee		complications that only one cause of	it ceused n eech lin	the deeth.								-	t.	Approximate Interval Bety Onset end D	veen
Immediate Ceuse ( disease or conditio resulting in death)		a. NA	RCOTI	C AND A	ALCOH	OL INTO	XICA1	ION							
- '				Due to ton											

**Physiclan** /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death w. Departmant of Haelth and Mental Hygiana. Important: If them 27 is merked other than "naturel", or items 23a a pay injury or other treumetic event, its Mental Process.

Baltimore, Maryland 21215-0020

Funeral

by

Completed

Be P

that the death certificate be axecuted and attanding physician tha or the be datach signed by

P.O. Box 68760.

Records,

Division of Vital

To the Hospital or Attending Physician

Examiner Physician/Medicai by this within 24 hours aftar death.

To the Funeral Director: Aftar this completely filled in by the funaral

Be Completed

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To

Medical

29a. Certifier

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): Due to (or as e consequence of)

Due to (or as a consequence of):

25. Was cese referred to medical examiner? 1 X Yes 2 □ No 27. Manner of Death 1 Naturel

5 Pending investigation 2 Accident 6XX Could not be determined 3 Suicide 4 Homicide

28a. Dete of Injury (Month, Day Year) FOUND 9/27/97

FOUND: RESIDENCE

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ₹ Residenca 6 ☐ Other (Specify) 28b. Time of P 28c. Injury et Work? FOUNDARY 3:00 M 1 Yes

2(X) No

26. Place of Death (Check only one)

28d. Describe how Injury occurred UNKNOWN

24a. Was an eutopsy performed?

1 Yes

281. Location (Street and Number or Rural Route Number, City or Town, State) 5221 LAKE AVE. BALTIMORE, MARYLAND 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner as atated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 🗆 No

29b. Signar re and title of certifier

OCME

29c. License number

29d. Date signed (Month, Day, Year) SEPTEMBER 28, 1997

23b. Did tobacco use contribute to the cause of death?

1 Yee 2 No 3 Probably 4 Unknown

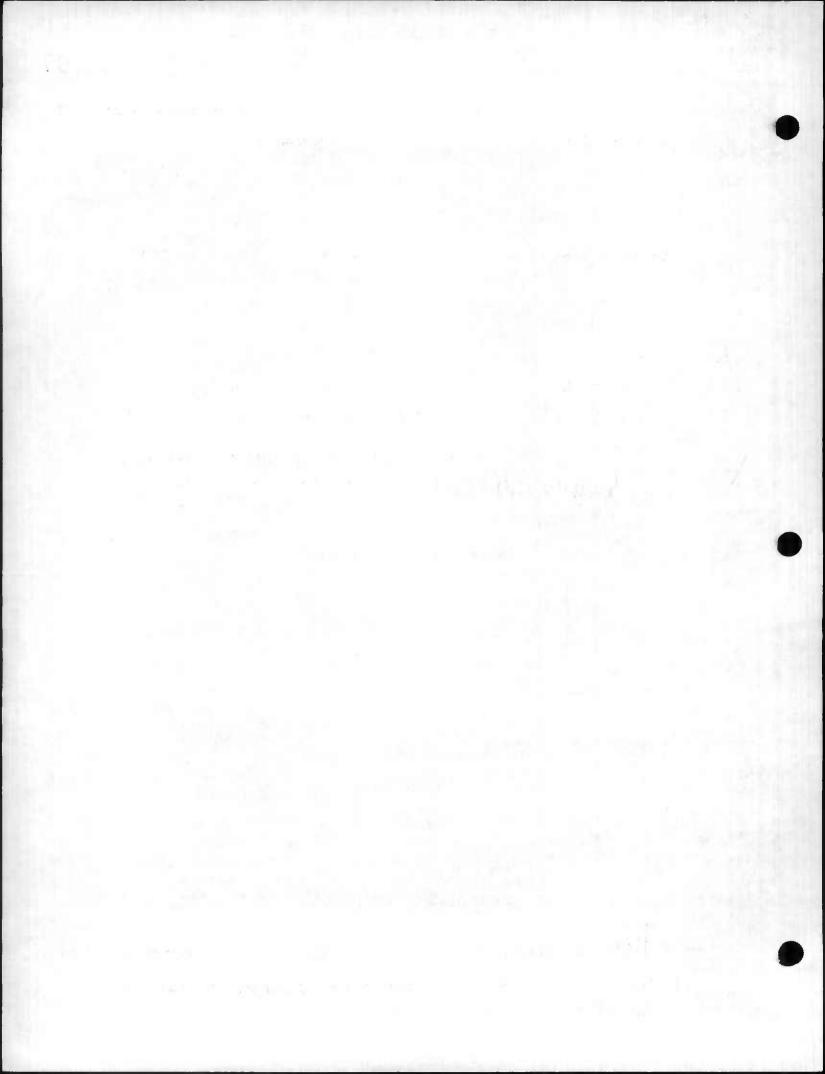
24b. Were autopsy findings available prior to completion of ceuse of death?

1 Yes 2□ No

of death (Item 23a) (Type, Print) KORoh

111 Penn Street, Baltimore, Maryland 21201

State Registrar



B.K.S

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

30598 DENNIS D. KIRBY Certificate of Death Items: 23a part I,27,28a-f per MEO G-752 10/14/97 dh 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth 3. Time of Death **Physician** De 1997 Yeer OCT. 4, 0938 AM DENNIS DREW KIRBY /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1738 WESTON ROAD PARKVILLE BALTIMORE If Under 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yaar) **Funeral** 1**√** M 2□ F Months Deys Hours Yrs. 41 Director 216-66-3266 10/5/55 MARYLAND Usuei Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-4 show notified Director 1 Yes 2 No BALTIMORE PARKVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 8 rs 23a 1738 WESTON ROAD 21234 USA Funeral 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify ğ 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Complet 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12th GRADE COUNTER MAN RESTAURANT Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Be Mantal marked EDGAR GORDON KIRBY 2 ROSE BRUNO 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) .86 Department Health Important: If Item 27 BALTIMORE, MD 1754 AMUSKAI ROAD 21234 ROSE ANN KIRBY SISTER 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation METRO CREMATORY, Inc. 10/7/97 CATONSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

The the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or complications that caused the death ock, or heert failure. List only one cause on each line, Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final NARCOTIC AND ALCOHOL INTOXICATION diseese or condition resulting in death) Examiner Due to (or es e consequence of) Examiner certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Lest pue Due to (or es e consequence of) 68760 Physician/Medical the th Due to (or es e consequança of) Box ed by the a Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? o signed by t 0 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably law requires that þ Records, been si 24b. Were autopsy findings aveileble prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? page The 1 Yes 2 □ No XYes 2 No certificate Vital Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certifics stely filled in by the funeral director, t Be 25. Wes case refarred to medical 26. Plece of Death (Check only one) exeminer? Other: 4 Nursing Homa STA Rasidance 6 Other (Specify) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 10 WYes 2□ No of 28b. Time of Injury Certification: 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury et Work? A Division 1 Natural 5 Pending Investigation 1 ☐ Yes 2 XXNo 10/4/97 found:9:35M 2 Accident unknown 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1738 Weston Road, 4 T Homicide found: home Parkville, Baltimore Co., Maryland within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.

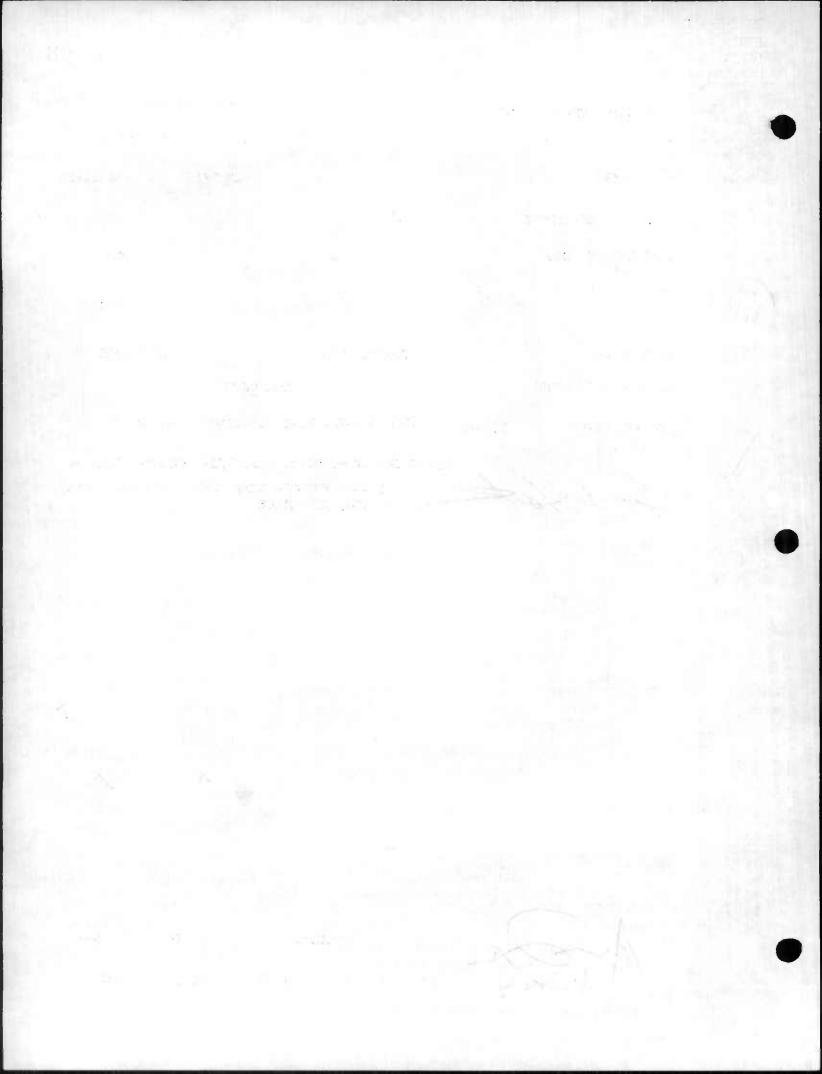
23.Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner steted. Medical (Check only one) 29b. Signature an title of pertition 29d. Data aigned (Month, Day, Year) 29c. Licansa number OCT. 05. 1997 O.C.M.E 30. Name and at person completer cause of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Data filad (Month, Dey, Year) 32 Registrar's Signature

ia Davidson-Randalle

State Registrar

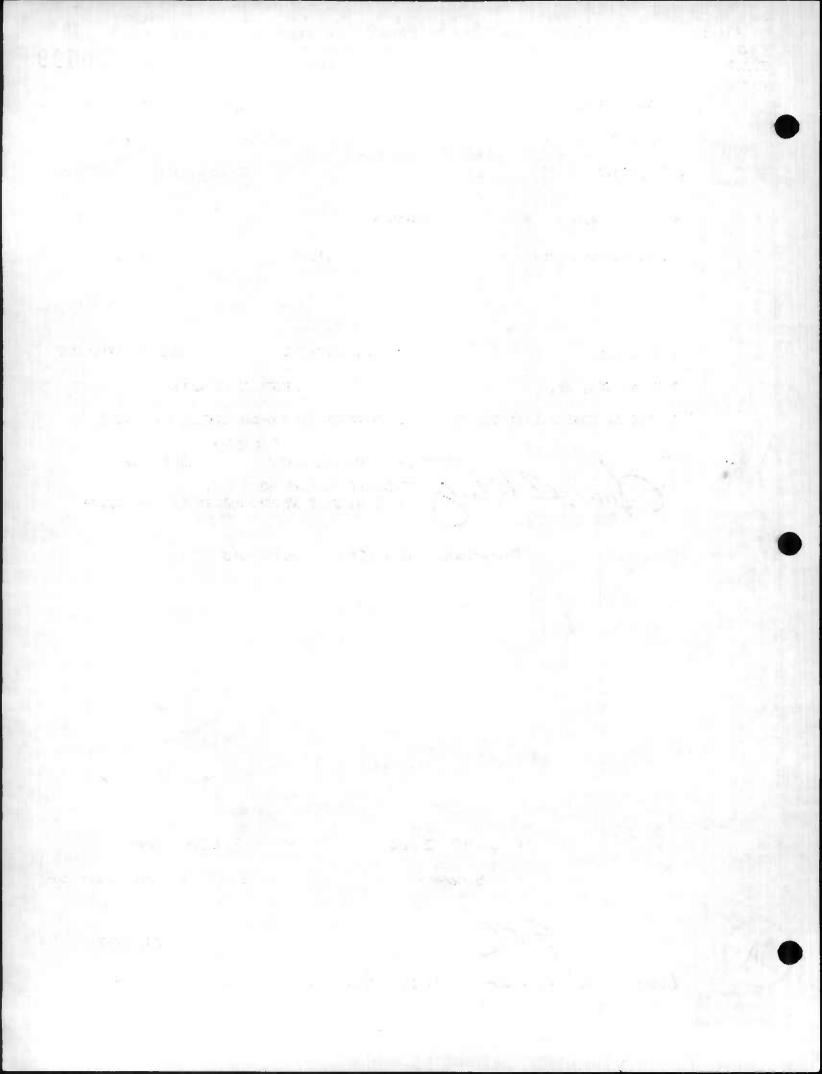
0 9 1997

**DHMH 16 Rev 6/95** 



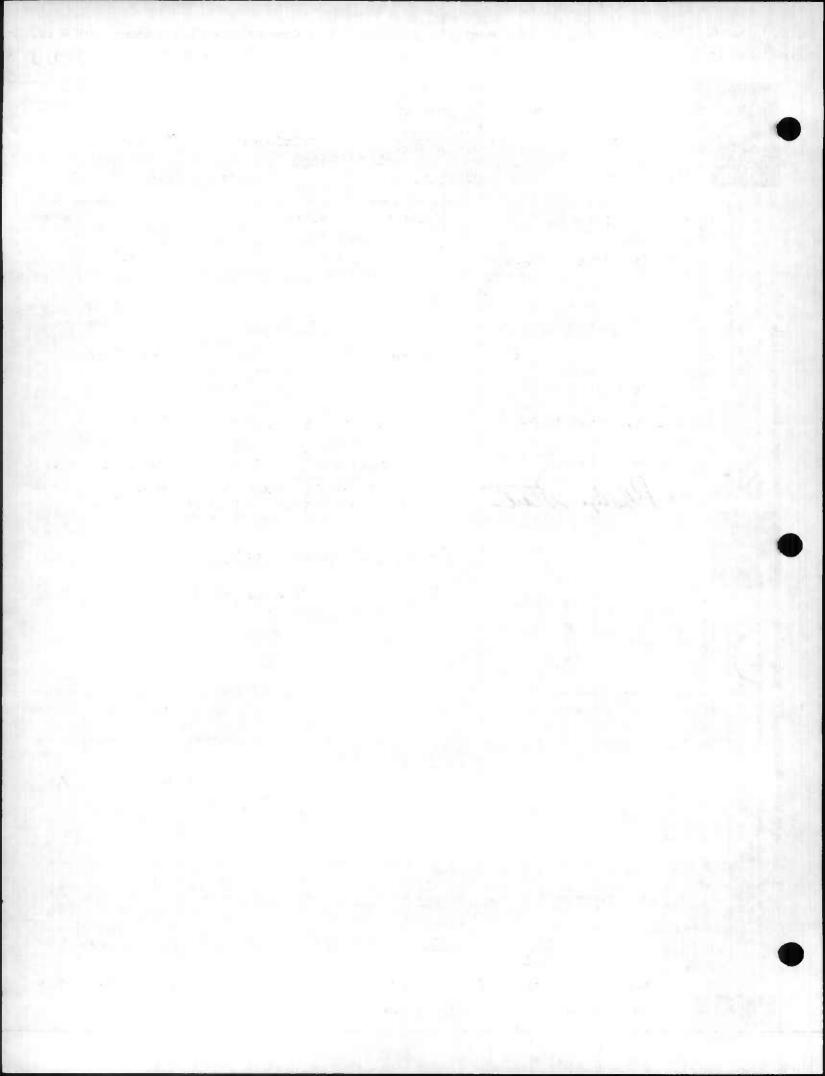
State of Maryland / Department of Health and Mental Hygiene 97 30599

							001	imouto	01	Death			Reg. No.		
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Examir		4a. Facility Neme	(If not institution OR HOSP:		number)				4			ocation of Dae	th 4c. Count	ty of Deeth	
Funeral Director		5. Social Security 219-29-3	3277	6. Sex 1 🛣 M 2 □ F		(In yrs. lest	birthday) Yrs.	If Under 1 Months D	Yaar Deys	if Under Hours	24 Hrs. Min.	8. Data of B (Month, D APRIL	irth 69, Year) 4,1978	9. Birthi Coul MA	plece (Stete or Foreign ntry) RYLAND
28a-f show	or	Usuel Residence 10a. Stete MD	of Decedeni 10b. County N/A			10c. City, To	own or Loc								10d. Inside City Limits
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0 8								10f. Zip Co					10g. Citizan of		ntry?
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end Mental a marked o aumatic ev	To B	BOYD K	EATON,	JR.						CAI	HER	INE ZEL	LMER		
575		19e. Informent's CATHER		hip (Type, Print) TON, III (N	40ТНЕ							el Route Numi BALTIMO	ber, City or Town	2122	
Dontrement of Heal Important: If Item 2 any Injury or other ance.				3 □Removel from	m Steta	ceme	tery, crem	eition (Neme etory or othe	r plac			0/8/97	20c. Location		own, Stata
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s been sign 2 should be	Completed by										-	24a. We	s en eutopsy formed?	SV CO	ere eutopsy findings rellable prior to implation of cause deeth?
page page	Con											19	Yes 2 No	15	Yes 2□ No
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and do o	0	XXYes 2□	] No	Hospital: 1	Inpatien	t 25 ER/0	Outpetient	3□ DOA	Oth	er: 4□ Nu	rsing Ho	me 5 Res	idenca 6 🗆 Ot	her (Specif	(y)
us certific i director,					e of Injury onth, Day	Year) 28b	. Time of Injury	28c.	Injun	y at k?		28d. Describe	how Injury occu		
har this certific menal director.	-	27. Menner of Dec	5   Pendin		-4-	97 2	104	0.0		Yes 2 D	No	Subi	ect sh	4	
sath, or. After this certific the funeral director,	-	1 ☐ Naturel 2 ☐ Accident	5 Pendin- Investig										101	har or Due	
its after death, all Director: Atter this certific led in by the funeral director,		1 Naturel	Investig	ot be		y - At home, (Specify)	farm, stre	et, factory, of	ffice			28f. Location City or To	wn, State)	てつしし	Poute Number,
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State of Maryland / Department of Health and Mental Hygiene 97 30600

	1. Decedent's Nei	me (First, Midd	lle, Last)								2. Date of Dee	eth Day	Veer	3. Time of Death
sician edical	Ed	ith	Mae	e	Lu	fburr	ο₩				October	Day 19	97	4:451
miner	4a. Facility Neme	(If not institution	n, give stree	et and num	nber)				4b. City, To	wn, or Lo	ocation of Death	4c. County	of Death	
	Windsor			ng Ce	enter				Balt				altim	ore
rai lor	5. Social Security 148-30-3 Usual Residence	869	6. Sex 1 ☐ M		7. Age (In yrs	: last birthd	Months	er 1 Year s Days	if Under Hours	Min.	8. Date of Birt (Month, Day June 22	y, Year) 1, 1902	9. Birthp Coun Nev	place (State or Fore htry) Jersey
	10a. State	10b. County	1		10c. C	ity, Town or	Location						1	0d. Inside City Limi
Funeral Director	NJ	Monmo	outh			Atla	antic		Highla	ands				1 ☐ Yes 2130 N
Director	10e. Street and N	umber					10f. Z	ip Code				10g. Citizan of	What Coun	itry?
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a	1 He	ellips	XIG	ule							e Balti		State, Zip Code) 14 City or Town, State C Highlands 21228	228
	23a. Part1. Enter shock, or he	the disease, or	r complicatio	ons thet ca	aused the dea	th. Do not	enter the mo	ode of dyi	ng, such as	cerdiac	or respiratory ar	rest,		Approximate Interval Between
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at	Immediate Cause disease or conditi	(Final				~	4 4	11						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene CHARLOTTE Certificate of Death LEWIS 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Yaar CHARLOTTE MAGDELINE LEWIS Octo BER 10:AM 7 1997 /Medical 4a. Facility Nama (If not institution, giva street and numbar) 4b City Town or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE
If Under 1 Year If Under 24 Hrs. 8. Data of Birth
(Month, Day, Year) 903 FORWOOD COURT 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 ■ M 2 XF 212-20-9926 Yrs Director 68 NOV 11 1928 MARYLAND Usual Rasidance of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23a or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director BALTIMORE BALTIMORE 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 903 FORWOOD COURT Funeral 21222 death USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours efter to Department of Health and Mentel Hygiene. Important: if itsan 27 is marked other than "naturel, or itse may loury or other traumetic event, the Medical Examines ones. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: p Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Sacondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be 2 JOHN FRIEDEL WINIFRED SPONSLER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) ALONZO LEWIS, HUSBAND 903 FORWOOD CT. DUNDALK, MD 21222 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a, Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) CHESAPEAKE CREMATORY BELTSVILLE, MD 10 - 3of Funeral Service Licensee 22. Nama and Address of Facility
BRADLEY-ASHTON-DABROWSKI-MATTHEWS FUNERAL HOME, I. C. 2134 WILLOW SPRING ROAD DUNDALK, MD aules 2134 WILLOW SPRING ROAD DUND.

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onsat and Death **Physician** /Medicai immediata Causa (Final ARTERIOSCIEROTIE CARDINASCULAR DISOASE disaasa or condition rasulting in daath) Examiner physician and s the burial-trens Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undartying Causa (Disaasa or Injury that initiated avants rasuiting in daath) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. ChronicoBSTRUCTIVE PULMOTARY DISOASE signed by I 1 Yee 2 No 3 Probably 4 Honknown Records, Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? complation of ceuse of death? 1 Yas 2 No 1 ☐ Yas 2 D No Division of Vital 25. Was casa rafarrad to medical Be 26. Placa of Death (Check only ona) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 10 1 Inpatiant 2 ER/Outpatiant 3 DOA this funeral 27. Manner of Death 1 Natural 28c. Injury at Work? To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred Certification: 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Description of the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai rinditia of certifiar 29b. Sanal 29d. Data signed (Month, Day, Year) 29c. Licansa number

32. Pegistrar's Signatura

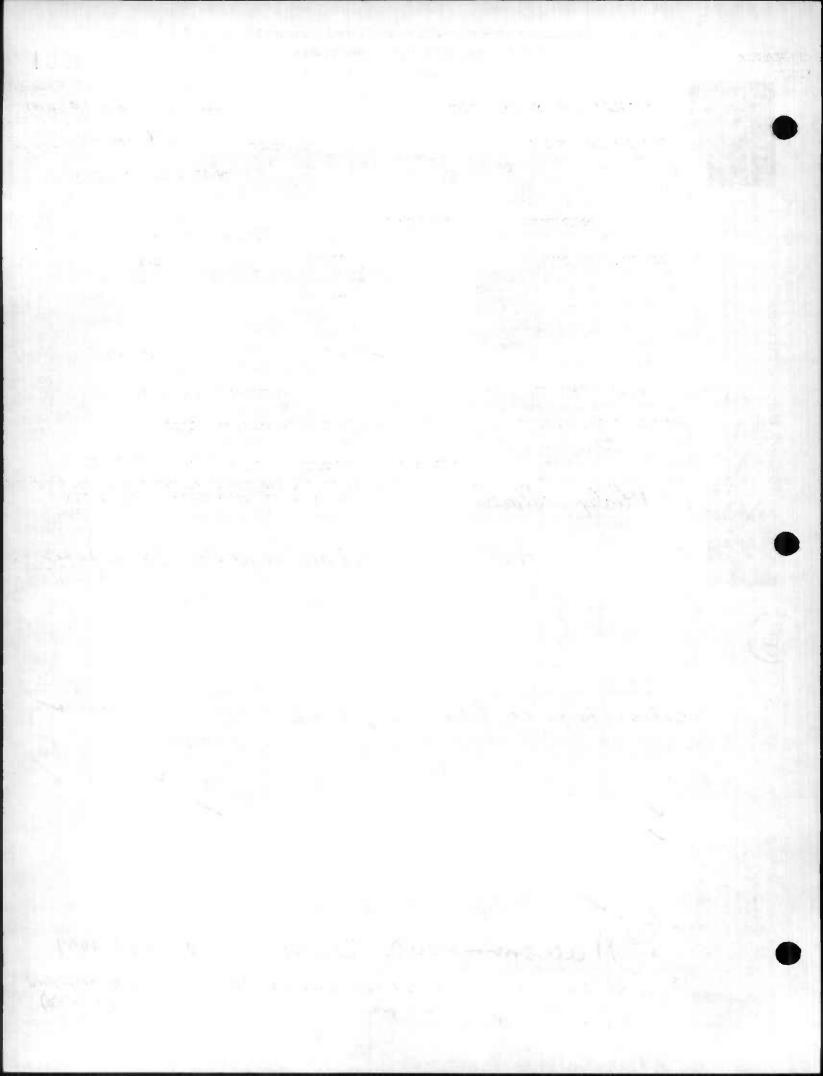
405 the delickAve CATUNSVILLE MARGHAND

unatura (230)

State Registrar 31. Data filed (Month, Day, Year)

30. Nama and addrass of person who complated or

DCT 0 9 1997



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day **Physician** Month Yeer LANE October 8,1997 Jeanette 12:15 P.M. /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale Franklin Square Hospital Center 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foraign Country)
 GA 5. Sociel Security Number 6. Sex **Funeral** 1□ M 2□ F Vrs. 212-46-4219 Director Usuel Residence of Dacadent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Md. NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 238 8700 Blairwood Road Apt.A-2 21236 USA e filed within 72 hours after death vall Hygiene.
other than "natural", or items 234 Funeral 12. Was Decadent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bieck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) I ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Nevar Merried 2 Married by Specify: Black 3 Widowed 4 □ Divorcad Completed 15. Decedant's Education (Specify only highest grade completed) 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Baltimore Co.Sch. Cotlaga (1-4or 5+) High Sch. Grad. Part-time NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) 2 should be fill and Mental H Is marked oth Be Arthur Howell Roxie Tillman 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Coda) permit. Pages 4-and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 6920 Floyd Avenue Springfield, VA. Perkins 22150 20b. Ptece of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete N Buriet 2 ☐ Cremetion 3 ☐ Removat from State 10 - 13 - 97Baltimore Cem. Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Feclity 21. Signeture of Funerel Service Licanses Baltimore, Maryland 21202 omson WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or confidentians that caused the deeth. Do not enter the mode of dying, such as cardlec or respiretory errest, shock, or haart failure. List on your causa on aach lina. Approximata Interval Batween Onset end Death **Physician** Immediata Causa (Finel disaasa or condition resulting In daath) /Medicai 18 hours e. Cerebrovascular accident Examiner Dua to (or es a consequence of): Examiner Hypertension Sequentielly list conditions, if eny, teading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of) Physician/Medical Due to (or es e consequence of) ŏ ed by the a Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown Diabetes Mellitus Completed by 24b. Were eutopsy findings evalleble prior to completion of cause of daath? 24e. Wes en eutopsy page 2 s has 1□ Yes 2□ No 1 Yes 2 No 25. Was casa raferred to medical exeminer? Be 26. Placa of Daeth (Check only one) exeminer/ 1 ☐ Yas 2 ☐ No Hospitel: → tnpatient 2 □ ER/Outpetient 3 □ DOA Othar: 4 Nurstng Homa 5 Rasidance 6 Othar (Specify) Certification: To 28a. Dete of Injury (Month, Day Year) funeral 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 5 Panding s after des.

I Director: After 1 ☐ Yes 2 ☐ No Investigetion 2 Accident 6 Coutd not be determined 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a edical 29a. Certifier i 🖰 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the besis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the cause(s) and menner steted. 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) October 8,1997 De D36663 30. Name and eddress of person who completed cause of daeth (Item 23a) (Type, Print) Dr. Stuart R. Willes 9000 Franklin Square Dr. Baltimore, Maryland 21237

State Registrar

31. Dete filed (Month, Day, Year) OCT 0 9 1997

Registrar's Signeture which Davidson-Randelle

the Maryland

Baltimore, Maryland 21215-0020

Box

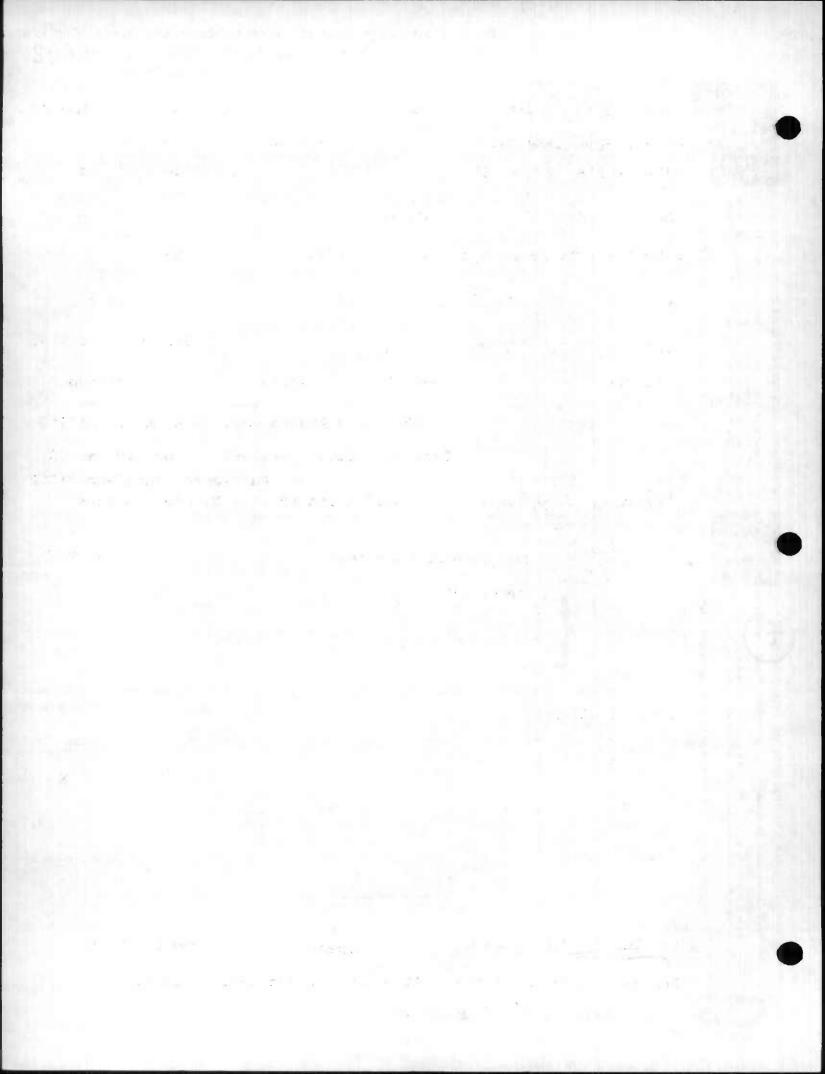
P.O.

Division of Vital Records,

or Attending Physician:

Hospital

this



WRC 97-5727-510 GENEVA MCLAVRIN

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

9

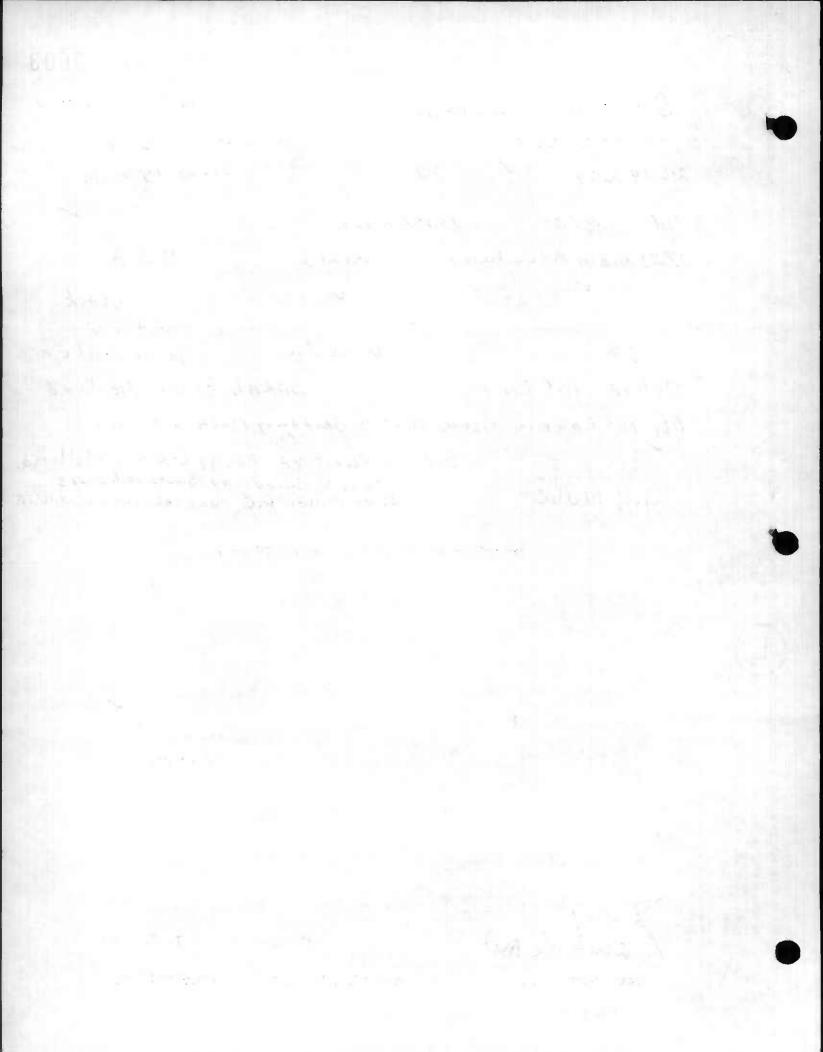
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					Ceru	ilcate of	Dealli		Reg. No.		
Physicia /Medic		1. Decedent's Name (First, Middle, GENEVA	Mc.L	AURIN	)			2. Date of October	06, <sup>D</sup> ¥997		3. Time of Death 3:45 PM.
Examin	er	4a. Facility Neme (If not institution, JOHNS HOPKINS		ber)			BAI	, or Location of Di	1	of Death	
Funeral Director		5. Social Security Number 216-24-3674 Usual Residence of Decedent	6. Sex 1  M 2	7. Age (In yrs. last b		f Under 1 Year Months Days		Hrs. 8. Date of (Month),	Birth Day, Year) - 28-14	9. Birthplace Sountry	ce (State or Foreign y)
ath with the Maryland 23a or 28a-f show	Director	10a. State 10b. County  Md N/	2	10c. City, Tov	tim	OVE					1. Inside City Limits
after des	by Funeral	10e. Street end Number  1823 Nick Th R  11. Marital Stetus  1 Never Merried 2 Marrie 3 Widowed 4 Divorced	12. Wes Deced Armed For	dent Ever in U.S. ces? 2 17 No	13. Was	10f. Zip Code  2/2 s Decedent of less, specify Cub		? (Specify Yes or uerto Rican, etc.)	No- 14. Rac Bla Specifi	ce - American	n Indian, c.
d within 72 giene. r than "nat	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-		(Give kin	t's Usual Occu d of work done NOT use retire D D M E	during most of		16b. Kind of B		
stant 2 should be filled Hear and Mental Hygis ftem 27 s marked other other traumatic event,	To Be C	17. Father's Name (First, Middle, L CALISE WI 19a. informent's Neme/Relationsh	e Lou	d	h Mailine	Addrana (Stran	SAY	2ph E	Ho Maiden Sumar EllEN mber, City or Town	Mc 1	loud
Physician   Medical Examiner of the Medical Examiner		1 Buriai 2 Cremation 4 Donation 5 Other (Spi 21. Signature of Funeral Service L  23a Parti. Enfer the disease, or or shock, or heart failure. List of  Immediate Cause (Finel disease or condition resulting in death)	cerity) censee  complications thet can be cause on ear	used the death. Do ch line.	22. N TE not enter t	Foves ame and Addre 639 A FF M he mode of dyin	ess of Eacility I Rev	10/14/9 od way D.C. Fu rdiac or respirator	BALte.	nd. 21	Alls Mills M
be is	niner		b	Due to (or es a	conseque	nce of):					
chilling executed	In/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a							
that the death	Physicia	Part II. Other eignificant condition	s contributing to dea	th but not resulting	in the unde	rrlying cause gi	ven in Pert I.		Old tobacco use co	ontributa to ti	
The law requires ate has been sign page 2 should be	Completed by							INS	Vas an autopsy erformed? PECTION □ Yes 2 🛭 No	comp of de	e sutopsy findings able prior to pletion of cause ath?
Physician: The this certificate ral director, page	To Be	25. Wes case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1   In	patient 2 DER/O	utpetient	3□ DOA Ot	hor	Death (Check or	esidence 6 □Otr	ner (Specify)	
l or Attending Physical date of the function o	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	28a. Date of (Month)	Injury 28b.	Time of tnjury	28c. Inju Wo M 1	rv et	28d. Descri	be how injury occur	rred	Route Number
Hospi 4 hou Funer taly fill	edicai Certii	4 Homicide determin	Physician: To the base	g, etc. (Specify) est of my knowledg	e, death oc	curred et the ti	me, dete and p	City or	Town, State) the ceuse(s) end m	anner es stet	ed.
To the within 2 To the comple	Mec	29b. Signature and title of certiler	deAD	or stated.		29c. Licen	se number		29d. Date signe OCT . 07		ıy, Year)
Stat	te	New and address of person w     J. Laron Locke     31. Date filed (Month, Day, Year)	M.D.				t, Balt	imore, M	Jaryland 2	21201	

DHMH 16 Rav 6/95

Registrar

OCT 0 9 1997



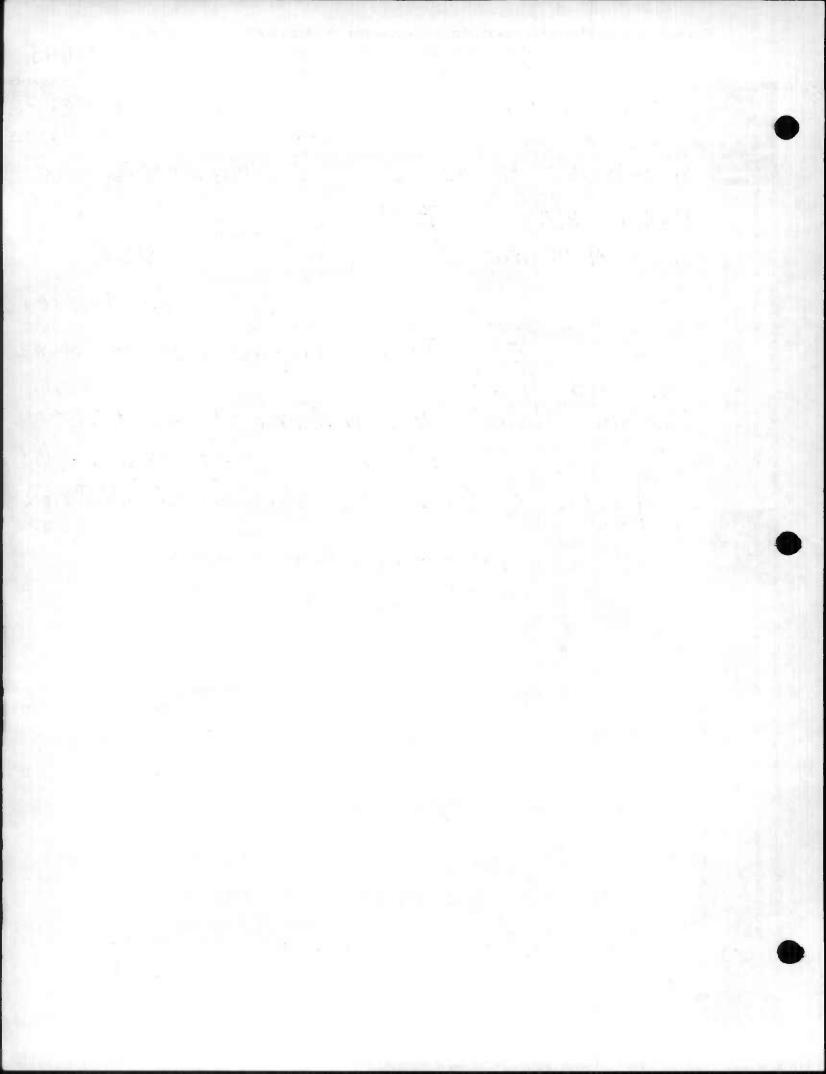
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 30601

		ITEM: 20b per FH G-752	10-9-97	Ce	rtificate	e of Death		Reg. No.	1 300	) U 4
Physic /Medi		1. Decedent's Nema (First, Middle, Les	M E	YER	ST	EIN	2. Date of D Month DCT 8.	eeth Dev	Yeer 15	of Death
Exami		4e. Fecility Neme (If not institution, give NO RTH WEST	HOSPITA			Ab. City, Town, or RAND A	LLSTON	IN BAL	TIMORE	
Funeral Director		5. Sociel Sacurity Number 6. S 174–26–9518 1  Usuel Residence of Decedent	ex 7. Age (In ) 84	yrs. last birthdey; Yrs.	Months	1 Yaar If Under 24 Hrs. Deys Hours Min.	8. Date of B (Month, D OCT .	20, 191	9. Birthplece (State Country) 2 GERMAN	or Foreign
with the Maryland a or 28s-f show be notified at	ctor	10a. Stata 10b. County  MD BALTI	A STATE OF THE STA	City, Town or Li		5			10d. Inside (	City Limits
ith with the	rai Director	10e. Street end Number 5612 TRIPLETT R	ROAD		10f. Zlp	Code 21117		10g. Citizen of V USA	Whet Country?	
72 hours effer death with the Manyland natural; or Items 23a or 28a-1 show death and the notified in	by Funeral	11. Maritel Stetus  1 □ Navar Marrled 2 ☑ Married  3 □ Widowed 4 □ Divorcad	12. Was Dacedent Ever I Armed Forcas? 1 ☐ Yes ANNO If Yes, Giva Yeer or Dates:	n U,S. 13.	Was Deceded of Yes, special Yes 2	ent of HispenIc Origin? (S fy Cuban, Maxican, Puert XNo Specify:	pecify Yes or N o Rican, etc.)	o- 14. Rac Bled Specify	e - Amarican Indian, ck, Whita, etc. WHITE	
within ene. then "	Completed	15. Decadeni's Ed (Specify only highast gra Elamantary/Secondary (0-12)	ucation de com <i>pleted)</i> Collaga (1-4or 5+)	16a. Dece (Give life.	kind of wor DO NOT us	Occupetion k done during most of wor a retired)  SWOMAN	king	16b. Kind of Bu	usiness/Industry	
電子を言	Be Co	17. Fether's Nema (First, Middle, Lest)			DALL		ne (First, Middle	a, Maiden Sumam		
should be nd Mental markad	ToB	PAUL		GEYER		SALCI	[A		KANDEL	
d 2 strain are train		19e. Informent's Neme/Ralationship (7 RALPH MEYERSTEIN				(Street end Number or Ru ETT RD; OWIN				
mit. Pages 1 en partment of Heal portant: If Item 2 y Injury or other		20a. Method of Disposition 1 X Kurial 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removel from State	b. Plece of Dispo cemetery, cre.	metory or ot	har plece)	Dete 0-8-97		City or Town, Stete	
permit. Pag Department Important: I any Injury o	2 1	Signetura of Funeral Servica Licen     Servica Licen     Servica Licen     Servica Licen     Servica Licen     Servica Licen     Servica Licen     Servica Licen     Servica Licen     Servica Licen     Servica Licen	atter	8	SOL LI	Address of Fecility EVINSON & BR EISTERSTOWN of dying, such as cardiac	RD: PIK	ESVILLE,	Approxima Intervel Be	ite etween
Physician /Medical Examiner	ier	Immediate Ceusa (Final diseasa or condition resulting in death)	e. ACUTE	M 70		RDIAL	INFA	ARCTIO	Onset end	Death
A	Examine	Sequentially list conditions, if any, leading to Immediate cause. Entar Undertying Ceuse (Disease or injury	b. Dua t	o (or es e conse	quanca of);					
ath sertificate by estanding physic for use as the h	n/Medical	Ceuse (Disease or injury thet initieted evants rasulting in deeth) Lest	Due to	o (or as a consec	quence of):					
that the death led by the stirr detached for	Physician/I	Pert II. Other significant conditions co	entributing to death but not	resulting in the u	inderlying ca	use given In Part I.			ntribute to the cause	•
es that igned b	by Pl						1	Yes 2□No	3 Probably 45	Unknown
ew requires to been s	Completed							s en eutopsy ormed?	24b. Were eutopsy eveileble prior completion of of death?	to
The ate							10	Yas 20 No	1 ☐ Yes 20	2NO
Physician: The this certificate ral director, par	o Be	25. Wes casa rafarrad to medical axaminer?	Hospital: 1			26. Place of Des		Manual - St		-
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To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29e. Cartifier (Check only one) Certifying Phy	vslclen: To the best of my Iner: On the basis of examend menner stated.	knowledge, deeti nination and/or in	h occurred e vestigetion,	t the time, data and placa In my opinion, death occu	, and due to the rred at tha lime	e ceusa(s) and me , date end pleca,	ennar es stetad. and due to the ceusa(	(s)
To the within To the comple	M	29b. Signeture end title of cartifier	Numi le	0	29c.	D 3733	3	BCTOBI	d (Month, Day, Year) ER 7, 1	997
V		30. Nema and eddress of person who o	complated cause of deeth (	Itam 23a) (Type,	Print)	10. MD				
Sta	ite	31. Dete filled (Month, Day, Year)	32. Registrer's Si			HE LO	77		A. A. E.	

TOPIN DISTRICT

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 30605

			Cerunc	ate of L	Jeath	Re	g. No.		0000
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sician Pauline	e Par	ker				10	7	97	556
miner 4e. Fecility Name (If not	t institution, give :	street and number)	101	4	b. City, Town, or I	ocation of Deeth	4c. County		0.1
Univ of		land Medic			Baltimor			more	City
5. Sociel Security Number 17-16-77 Usuel Residence of Dec	37A 10	7. Age (In yrs.	last birthday) If Un Monti	der 1 Year hs Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth Month, Day	1404 P	9. Birthplec	e (State or Foreign
	b. County	10c. Ci	ity, Town or Location	044				10d.	fnside City Limits
Maryland  10e. Street end Number	IV I			MOT (	<u></u>	110	Dg. Citizen of W	Vhet Country	1 Yes 2 No
	N. Mc	nroe S	t.	210	217		u	SA	
11. Meritel Stetus 1 Never Married 3 Widowed 4	2 Married	12. Wes Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes;		pecify Cube 2 No	spanic Origin? (Sin, Mexicen, Puert Specify:	pecify Yes or No- o Rican, etc.)		- American k, White, etc	
15.	. Decedent's Educ	cation e completed)	16e. Decedent's U	suel Occupe work done d	ation Juring most of wor	kina	16b. Kind of Bu	siness/indus	try
Elementer/Seconder		College (1-4or 5+)	life. DO NO	T use retired,	furing most of wor		Nut	ida	Line
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o Richa	ird	Thomas						un	Known
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20e. Method of Disposit	ria 1	nornton	Plece of Disposition (	/V./V	lonroe	Date /	Dalto 20c. Location -	City or Town	2/2/1/ State
1 Burial 2 Cr	remetion 3 DR		cemetery, cremetory	or other plece	9)	10/13/97	Lans	dout	ne, Md
21. Signature of Funera	al Service Lidense	· OID	22. Name	and Addres	s of Fecility	C Eu	nora	1 40	me
TO THE REAL PROPERTY.	Sph	L. Kul	11/22	E U	TNOCT	FAUE	Ball	to, Ma	1.21216
	ilum. List only on	cations that caused the dea se cause on each line.	th. Do not enter the r	node of dying	g, such as cardiac	or respiretory erre	est,	i In	pproximete tervel Between nset and Deeth
Immediate Ceuse (Fine	əl		1	1		0.11	0 +		200
disease or condition resulting in death)	9	Sepsis se	or es e consequence	10 60 of):	irgrenou	SKight	100191	5	
iner	_ h	Anemia						1	
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resulting in death) Lest		Due to (d	or es e consequence d	01):					
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Part II. Other eignifican						1 🗆 Ye			ly 4 Unknown
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peted						24e. Wes ar perform	n eutopsy ned?	aveile	autopsy findings ble prior to etion of cause
								of dee	th?
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25. Wes case referred to examiner?  1   Yes   2   No  27. Menner of Deeth 1   Neturel   5 2   Accident 3   Suicide   6 4   Homicide	Pending investigation Could not be determined	28e. Date of Injury (Month, Dey Year)  28e. Plece of Injury - At h building, etc. (Special Iclan: To the best of my knower: On the best of exemina	28b. Time of fnjury M ome, ferm, street, fecty)  owledge, deeth occurry	28c. fnjury Work 1 1 1 tory, offica	er: 4 Nursing H et er: 'C' 'C' 'C' 'C' 'C' 'C' 'C' 'C' 'C' 'C	ome 5 Reside 28d. Describe ho 28f. Location (Str. City or Town	nce 6 Otherwinjury occurrence on the Number of State)	ed  or Rurel Runner as stete	d.
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WRC 97-5686-005 ALVAH PEARSON

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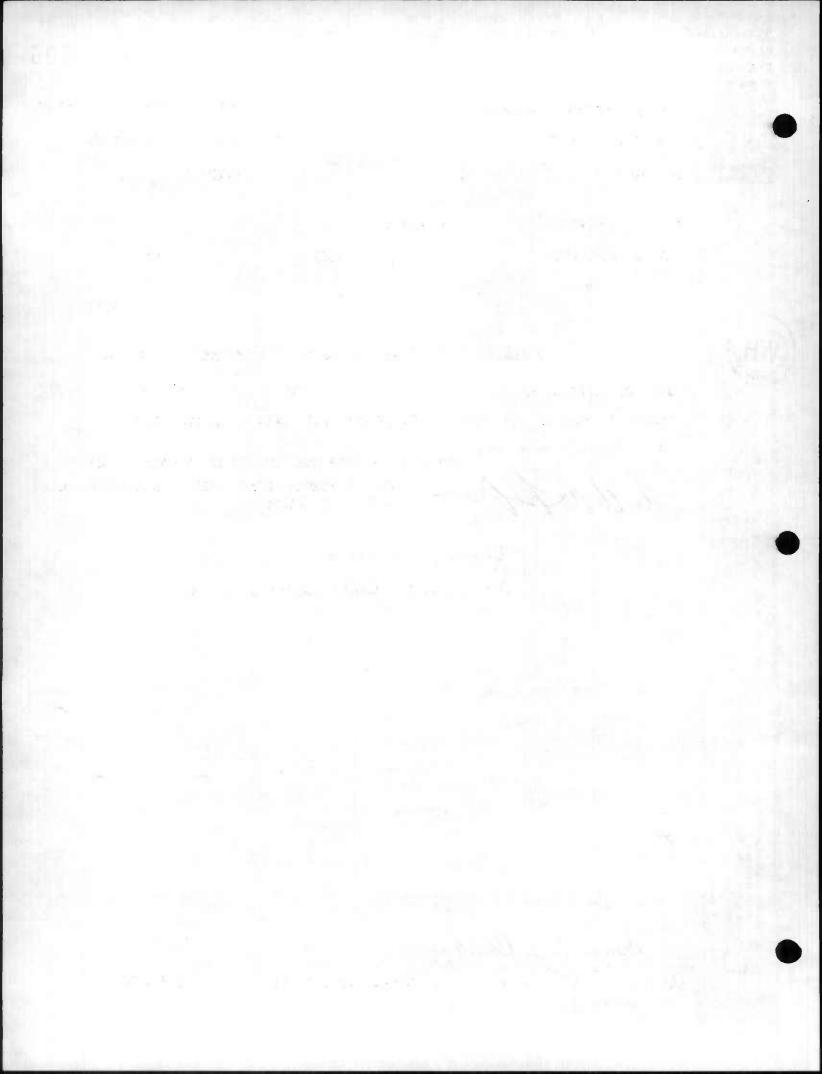
State of Maryland / Department of Health and Mental Hygiene

30606

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1997 **Physician** Month 05, OCT. 6:34 AM ALVAH LEONARD PEARSON /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST HOSPITAL BALTIMORE BALTIMORE 5. Social Security Number if Under 1 Yeer If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Deys XXM 2 F Yrs. Director 546-92-4537 43 8/28/54 VA 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗙 No 28a-1 CA SOLANO VACAVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ö must be 23a 177 JEARBET WAY 95687 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritai Status 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: A Specify 3 Widowed 4 Divorcad WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 2 YRS CERTIFIED WELDING INSTRUCTOR WELDING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 0 ANN GLOVER SHACKELFORD IRA G. PEARSON, SR. Mary 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Hem 27 DOROTHY J. PEARSON WIFE 177 KEARNEY WAY VACAVILLE, CA altimore, Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1 X Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) VACAVILLE ELMIRA CEMETERY 10/13 VACAVILLE, CA 22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 ne disease, or contribute that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it failure. List only one ceuse on each line. Interval Between Onset and Death **Physician** Immediete Cause (Final Coronary disease or condition resulting in death) **Examiner** Cardiovascular Disease the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of) burial-tran Box 68760 Physician/Medical the Due to (or as a consequence of) USB BSU P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown The law requires that Records, þ 8 Completed 24a. Was en eutopsy performed? 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 10 Yes 2 No Mes 2□ No certificate of Vital Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 【 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this 27. Manner of Death 28a. Date of fnjury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division V Abetural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No efter deeth filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 6 Hospital 624 hours e within 24 hours edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. the 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OCT. 06, 1997 30. Neme and eddress of person who pleted cause of deeth (Item 23a) (Type, Print) Dennis hute no 111 Penn Street, Baltimore, Maryland 21201 State Signature Signature a Day door

Registrar



State of Maryland / Department of Health and Mental Hygiene 97

97 30607

					Cei	rtificate	of	Death		F	Reg. No.		00007
Physic	ian	1. Decedent's Neme (First, Middle	inovich	100						2. Dete of Dee Month	oth Dey	Yeer	3. Time of Deeth
/Medi	cai	Betya Kab  40. Facility Name (If not institution		um <i>ber</i> )			- 1	4b. City. To	wn. or L	October ocation of Deeth	5 4c Coun	1997 ty of Death	7:13 PM
Exami	ıer	Sinai Hospita						Balt			N/		
Funeral Director		5. Sociel Security Number 216–94–7552	6. Sex 1 ☐ M 2 ☐ xF	7. Age (In yrs. 84	last birthday) Yrs.	If Under	Deys		24 Hrs. Min.	8. Date of Birth Month Dep	1913		olace (State or Foreign
and w.		Usual Residence of Decedent  10a. Stete 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
tar death with the Marylan Herns 23s or 28s-f show	Director	MARYLAND BAI	TIMORE			BA		IMORE			,		1 □ Yes 2 No
ath with 123a or 3		10e. Street end Number 6800 BROOKMILL	ROAD			10f. Zip (	21	5			10g. Citizen of RUS	What Cour SSIA	itry?
5-0020 72 hours after death with the Maryland natural; or items 23s or 28s-f show oreal Examples in the neutrod of	by Funeral	11. Merital Stetus 1 □ Never Merried 2 □ Marr 3 ☎ Widowed 4 □ Divorced	Armed F	2 XNo		Wes Decede f Yes, speci l□Yes 2				ecify Yes or No- Rican, etc.)		ice - Americ eck, White, ify:	
21215-0020 ad within 72 hours af gignes. or than "natural", or the managed by the control of the	Completed	15. Decedent (Specify only highest Elementery/Secondery (0-12)	t grede completed	() (1-4or 5+)	(Give	lent's Usuel kind of work DO NOT use	done	during mos	t of work	ring	16b. Kind ot I		
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Balling permit Department: Important: any Injury		21. Signature of Funeral Service	icens		80	Name and	1 <sup>dd</sup>	evins	on 8	Bros.,	Inc.	a. MD	21.208
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axecute an and in litrans	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	Ь.	Due to (c	r es a conseq	uence of):			_				
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requiper /	Completed	Gastric Ulcer						,.		24a. Wes e	en eutopsy med?	COL	ere autopsy tindings elieble prior to mpletion ot cause deeth?
= F # d	Com									1 🗆 Y	es 2 No	10	Yes 2 No
Of VItal Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:						of Deet	h (Check only or	ne)		
Phys ral di	To	1 ☐ Yes 2 📜 No 27. Manner ot Deeth	28a. Dete		ER/Outpetlen 28b. Time of		c. Inju		7	ome 5 Resid			)
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DIVI  To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier t Certifying (Check only one) Certifying	Physician: To the end men	e best of my kno basis of exemine oner stated.	wledge, deeth tion end/or inv	occurred el restigetion, i	t the ti	ime, dete en opinion, dee	d place, th occur	and due to the d red et the time, d	euse(s) end n lete end piece	nenner es st , end due to	eted. the cause(s)
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/Medical Examiner		cility Neme (If not institu									-	ocation of Dear	-	County	of Death	, ,,
Funeral Director	5. Soc	lal Security Number 12–41–3223	6. Se	х Эм 2 <b>□х</b> F	7. Age	(In yrs. last birth		If Under 1 Months I	Yeer		24 Hrs. Min.		rth av. Year 5,19	12	9. Birthpi Coun UKRA	iece (State or Foreig AINE
9 .		Residence of Decedent														
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or 28a-t se notifis	10e. S	treet and Number						10f. Zip C					10g. Ch	tizen of \	Whet Coun	try?
ral la	2	909 FALLSTA	FF R	D., AP	т. :	L8		2	120	)9				UKRA	INE	
natural, or thems 23s or 28s-1 sho sidel Examiner must be notified at sted by Funeral Director	10	rital Stetus  Never Merried 2 N  Widowed 4 Divorce		12. Wes Dec Armed F 1 Tes If Yes, G Year or I	orceş? 2 ☑XN ive			es Deceder Yes, specify		lispenic Ori en, Mexicar Specify:		ecify Yes or N Rican, etc.)	0-		ck, White, o	etc.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Per MD, 18 Per FH Film G-756 2-13- Certificate of Death 98RC Amended: 1. Decedent's Name (First, Middle, Last) 2. Defe of Death 3. Time of Death Month **Physician** Wilhelmina 0 /Medical 4e. Facility Name (If not institution, give street and number VILLAST. 4b. City, Town, or Location of Deeth 4c. County of Deet MICHAEL Examiner Balt clia If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Birthpiace (State or Foreign Country) **Funeral** Days 1 M 2 F Yrs. 218-12-3722 Director MD Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 PYes 2□ No NIA Directo MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Counfry? Pages 1 and 2 should be filed within 72 hours after deeth with to any menth and Mental Hygiena.

The man of is marked other then "natural", or items 23a or 2 STREET **MAYSON** USA 809 21217 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decadent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American indien, Bieck, Whife, etc. 1 Never Merried 2 Merried Yes 2 No f Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1□ Yes 2☑ No þ 3 ☐ Widowed 4 ☐ Divorcad BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) SECRETARY DEPT. OF EQUICATIONS 12 TH GRADE YR9 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be MCNAIR WILHELMINA HARRIS KAWLINGS . WEBSIER 2 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing, Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) important if them 27 is a say injury or other traum once. ST. 809 NORTH PAYSON KHEUBOTIOM | NIECE BALTO. MD. 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dafe 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete METRO 10.9-97 BALTO. 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY 22. Name and Address of Fecility
VAUGHN C. GREENE 21. Signature of Funeral Service Licensee TUNERAL SERVICE 5151 BALTO. NATL PIKE BALTO. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onsef and Death Physiclan /Medical immediate Cause (Finel disease or condition resulting in death) 3 weeks ACUTE CEREBRAT THOM BOSTS Examiner Due to (or es e consequence of) Examiner The law requires that the deeth certificata be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of): physician s the buriel **Physician/Medicai** Due to (or es a consequence of): Part ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown HYPERTEUSON by 24b. Were autopsy findings avellable prior to Completed 24a. Was an autopsy performed? CHROME REVAL FAILURE completion of cause of death? 1 Tes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 1 inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Deeth 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Certification: 28a. Date of injury (Month, Dev Year) Affar 1 Naturel 5 Pending 1 Tes 2 No investigation death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760, 0 0 Division of Vital Records, or Attending Physician:

within 24 hours aftar death To the Funeral Director: / completaly filled in by the f Hospital

State

Registrar

Medical

29a. Certifier

1🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) and manner as stated. 2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number

of death (Item 23a) (Type Print)

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State of Maryland / Department of Health and Mental Hygiene

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30. Name end eddress of person who completed coluse of deeth (Item 23e) (Type, Print)  W. A. Riley GBMC 6761 N. Charles St. Balto. Md 21204	
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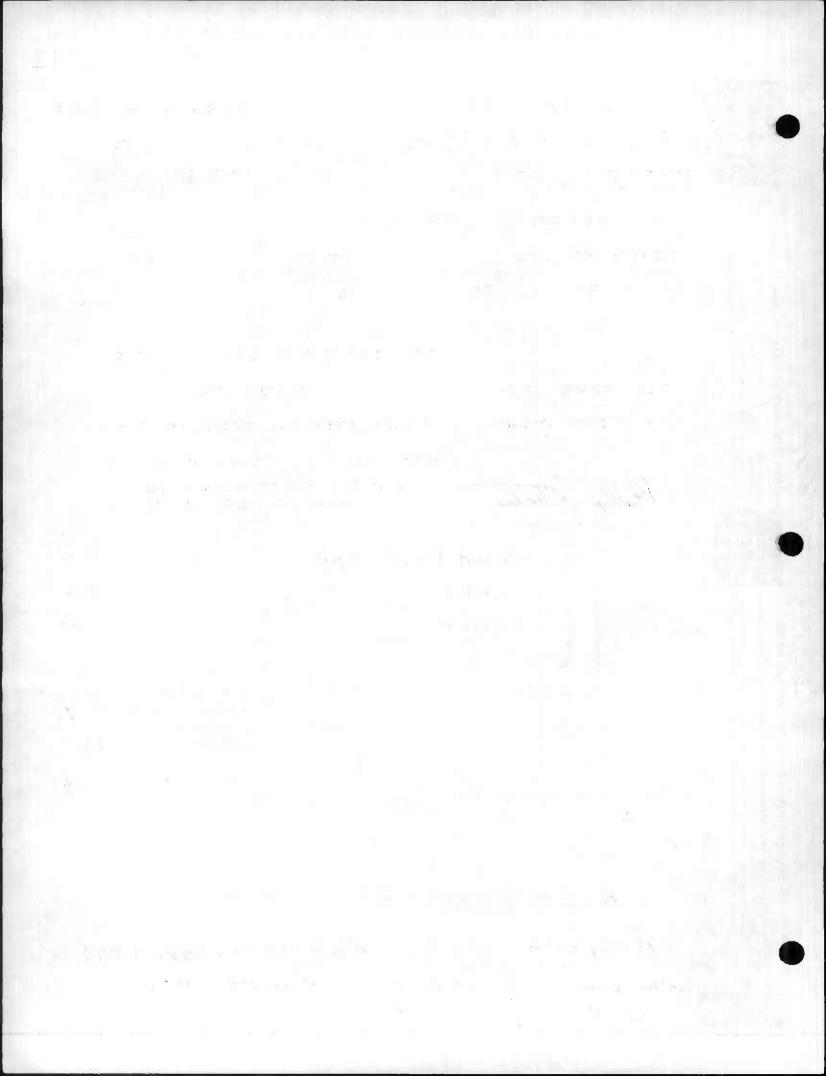
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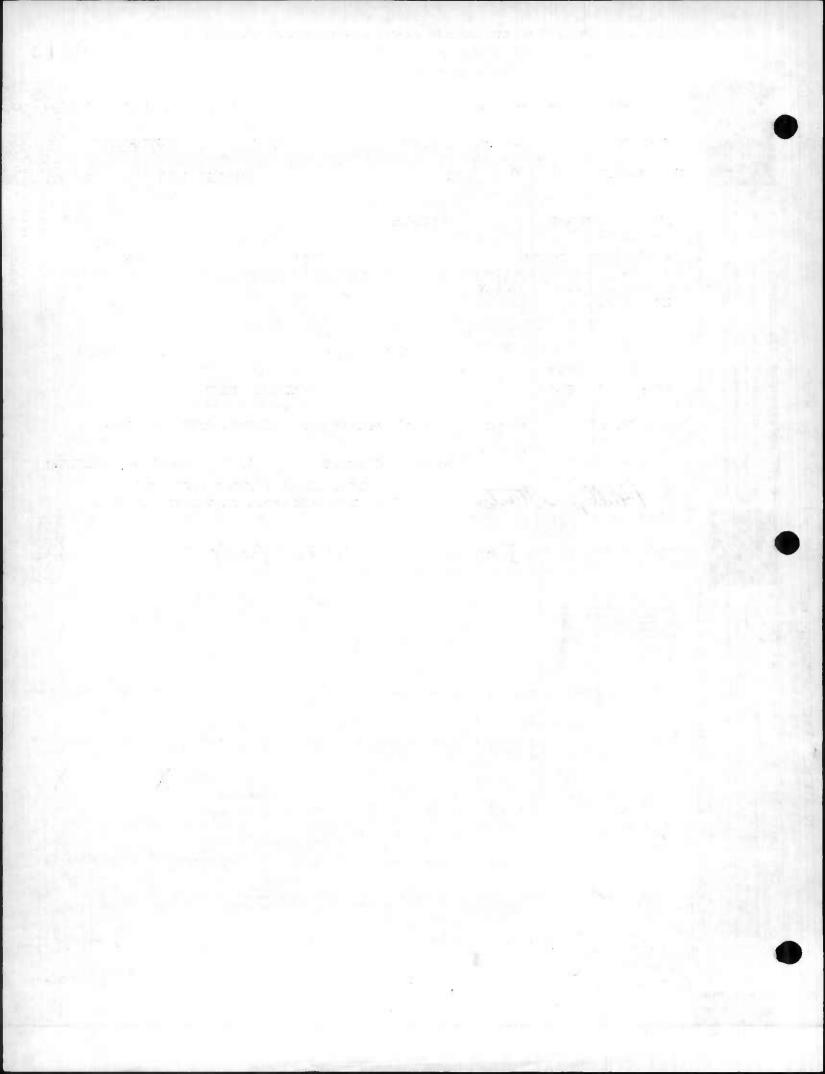
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Physician	ī	Pert it. Other eignificant con-	ditions o	ontributing to d	eath but not result	ting In the u	ınderlying ce	use giv	an in Part	f.	23b. Did	tobacco use	contribute 1	to the caue	of deal
h.											1	Yee 2 N	o 3□Pro	bably 4	□Unkno
by P												,			
											24a. Wa	s an autopsy	24b. W	ere eutops	finding
Completed											peri	formed?	C	valiabla prio ompletion o	cause
d E												1/	O	death?	
											1 🗆	Yes 2 N	1	☐ Yes 2	No
Be		25. Was case referred to med examinar?	dicei					1		e of Deet	h (Check only	ona)			
2		1 ☐ Yes 2 No		Hospitei:	Inpatient 2 E	R/Outpatie	nt 3 DO	Oth	ner: 4 🗆 Ni	ursing Ho	me 5 Res	idence 6 🗆	Othar (Speci	ity)	
		27. Manner of Deeth 1 Naturel 5 ☐ Pa	ndina	28a. Date	of injury	28b. Tima o	of 28	c. Injui	y et		28d. Dascribe	how injury oc	curred		
atic			estigetion			,,	М		Yes 2□	No					
150		3 Suicida 6 Co 4 Homicida del	uld not b ermined	289. Place	of Injury - At hon	ne, ferm, st	reet, factory,	office			28f. Location	(Street and Nu	mber or Rur	al Route Nu	mber,
Certification:		4   Hollicida		Dullo	ing, etc. (Specify)						City or 10	own, Stata)			
		29a. Certifier	fying Ph	veiclan: To the	best of my know	ledge deet	h occurred e	the tir	ma dete ar	nd place	and due to the	ceusa/s) end	menner es	stated	
edical		(Check only 2 Medi	cai Exan	niner: On the b	asis of examination	on and/or in	vestigetion,	in my c	pinion, das	ath occur	rad at tha tima	, deta and ple	ce, and dua	to the ceuse	(s)
M		29b. Signature end title of cer	tifiar	011011	mor stoled.		29c	Licans	a number			29d. Deta sig	ned (Month	Day Year	
	1	12 (1)		1,09	- MD	)				0					
		101.11	al		/ /			T	ノフラ			Octob	101/7	. //	17
	3	30. Neme end eddrass of pers	on who	completed caus	sa of daeth (item :	23a) (Type,	Print)	1	14	0 -	. ~ /-	ala	The se	7	
	6	AGRANG	14	AKEN	1 18111	caci	NECE	(in)	HICIO	0- D	1 2(2	- OLIV	12	083	2
ate	3	31. Dete filed (Month, Dey, Yo	ear)	33°F	Signetu	Jre.								-	
rar		OCT U 9	1997	84	a Davidson	-Mand	USZ,								
1 611															

DHMH 16 Rav 6/95

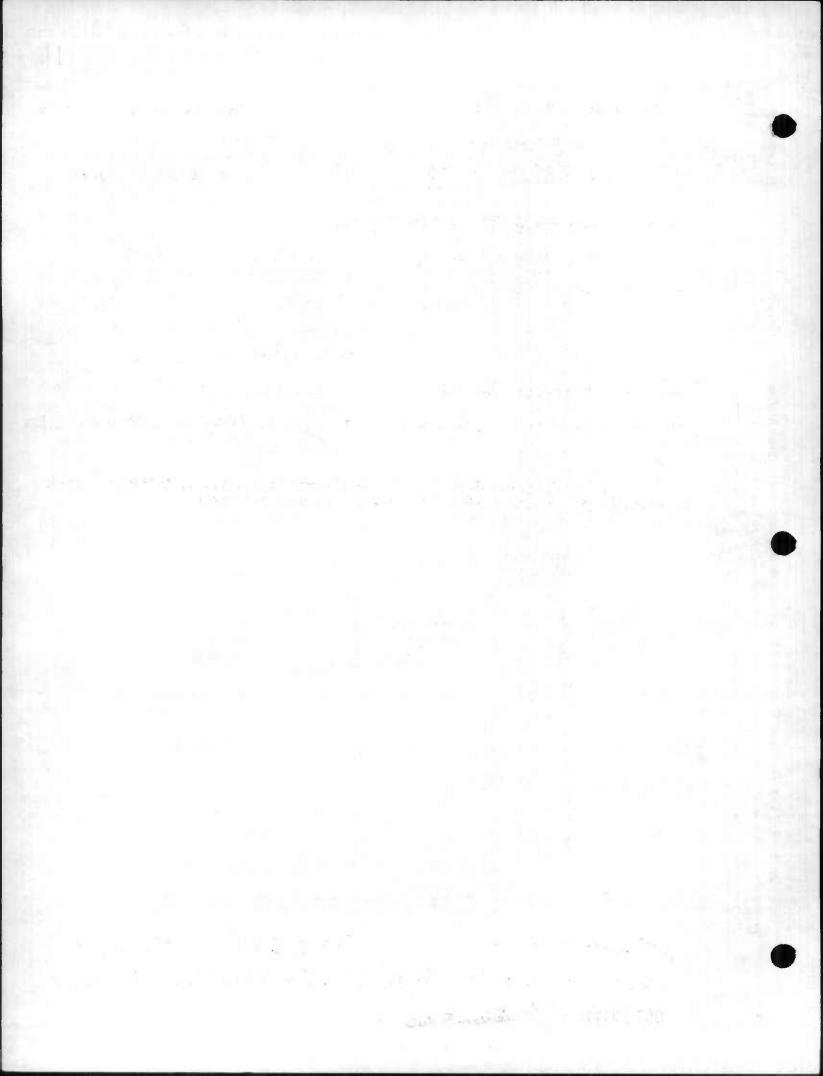
5:35 PA

10-03-97

Tye - Stumpner



		State of Maryland / Department of H Certificate of I		Reg. No	21	30514
Physic	ian	1. Decedent's Nama (First, Middle, Last)		eta of Death onth Da	v Year	3. Time of Death
/Medi		John Andrew Sunkel, Jr.		tember	16, 1997	1:35 pm
Exami	ner		b. City, Town, or Location		. County of Death	
		29 Winding Woods way	Pasaden		H.A.	
Funeral	100	5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  10 M 20 F  7. Age (In yrs. last birthday)  Months Days	Hours Min. (M	ite of Birth Jonth, Day, Year)	9. Birth	place (Stete or Foreign
Director		917-14-514/ 107M 2LF 73 Yrs. World Sugar Residence of Decedent		0-30-2	3	md.
and and		10a. Stete 10b. County 10c. City, Town or Location				10d. Inside City Limits
h the Marylan r 28a-f ahow	Ö	md Anne Arundel Pasadena				1□Yes 2 No
the 288	5	10e. Street and Number 10f. Zip Code		10g. Cit	izen of What Cou	ntrv?
23a or	ā	29 Winding Woods way	21122		115	
hours after death with the Maryland ural; or items 23a or 28a-f show at Examiner must be notified at	Funeral Director		Ispanic Origin? (Specify Youn, Mexican, Puerto Rican,	es or No-	14. Race - Ameri	can Indian,
after des or items		1 Nevar Married 2 Married 1 Pes 2 No		atc.)	Bleck, Whita,	atc.
alf, o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Giva Year or Dates: 1943 - 1945	Specify:		Specify: W	i te
72 hours natural,	Completed	15. Decedent's Education 16a. Decedent's Usual Occup (Specify only highest grade completed) (Give kind of work done of	ation	16b. K	ind of Business/In	dustry
within one.	nple	Elementery/Secondery (0-12) College (1-4or 5+) life. DO NOT use retired	during most of working	,		
filed with Hygiena. ther than	Co	12 0 Meat PACKER		2 F	ood	
d of H	Be	17. Fether's Nema (First, Middle, Last)	18. Mother's Neme (First	, Middle, Maiden	Sumeme)	
ould be Mental arked o	2	John Andrew Surkel SR	CARoline	CATHER	ine 5	ossman
L Pages 1 and 2 should be filed within ment of Health and Mental Hygiena. sant: If item 27-is marked other than tury or other traumatic avent, the Me		19e. Informent's Name/Relationship (Type, Print)  19b. Mailing Address (Street		le Number, City o	or Town, State, Zij	Code)
1 and Health Im 27-		Anna Sunkel wife 29 winding 20a, Method of Disposition (Neme of	woods w		sadena	Md 2/122
1 0 H		20a. Method of Disposition  1 ☐ Burlei 2 ☐ Cremation 3 ☐ Ramoval from State	Date Date	a 20c. Lo	ocation - City or T	own, State
Pag ment mrt: h		4 ☑ Donation 5 ☐ Other (Specify)				
Department Department Importment		21. Signature of Funaral Service Licensee Joseph B. Van Sant 22. Name end Addra State Anat	ss of Fecility Comy Board,	655 W. E	Baltimore	Street
20240			, Maryland 2			
	1	23a. Part X Enter the diseese, or complications that cabsed the death. Do not enter the mode of dyln shock, or heart feilura. List only one cause on each line.	g, such es cardiec or resp	Iratory arrest,		Approximate Interval Between
Physician					1	Onset and Deeth
/Medical Examiner		Immediate Cause (Final disease or condition A CVTE CENAL FA	ILUKE			
-WANTE OF	*	resulting in deeth)  Due to (or es a consequence of):			1	
B 16	Examiner	OEHYDRATION			- 1	
De executed ician and burial-transit	XBr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	7 PAILU	P =	1	
cate be easou physician and i the bunal-tra		If any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	1 PAICO	N.C.	i	
	edical		- Out 404	PU D	CNACT	
attending for use	3	chronic obstructive	- AU CHLON	NOT V	120126	
atter	Physician/M	Book Character Manager and Character and Cha				
es mat me de igned by the be detached	ys	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I. 2		.1	o the cause of death?
that the sed by detac		UXIGEN 7HORMY		1   Yes 2	No 3□Pro	bably 4 Unknown
uires tha signed lid be de	d by	OSTEOPOROSIS	24	4a. Was en auto	psv 24b. W	ere autopsy findings
The law requires that the death centi ata has been signed by the attending page 2 should be detached for use	Completed	031007000013		performed?	00	ailable prior to impletion of cause death?
he law	E G	DEPLESSION		.0	-	
		25. Wes case referred to medical	20.51		No 1	☐ Yes 2☐ No
Physician: The laths certificate he ral director, page	o Be	examiner? Hospital:	28. Place of Death (Che	448	а Пон	t.i
5 5 5	: To	27. Manner of Death 1 Description   1 Description   2 ER/Outpatient   3 DoA   Doa   27. Manner of Death   28a. Date of Injury   28b. Time of   28c.	4   Nursing Home 5	escribe how Inju	- ' '	γ)
To the Hospital or Attanding F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	tio		k? Yes 2 □ No	- 12 J. C. C. H.		
or Attanding Phitter death.  Director: After this in by the funeral	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory office	28f. Lo	cation (Street en	d Number or Run	al Routa Number,
d in t	Le l	4 ☐ Homicide building, atc. (Specify)	Ci	ty or Town, Stete	)	
apita nours neral		29e. Certifier 16 Certifying Phyalcian: To the best of my knowledge, death occurred at the time	ne, dete end placa, and du	e to the cause(s)	and manner as a	tated.
Full	edical	(Check only one) 2 ■ Medical Examiner: On the basis of examinetion and/or investigation, in my or end manner stated.	olnion, death occurred et the	he time, dete end	d place, and due t	the cause(s)
vithin 24 hours a vithin 24 hours a To the Funeral Completely filled	M	29b. Signature and title of certifier 29c. License	number	29d. Da	te signed (Month,	Day, Year)
		02	35621	0	1/20/0	77.
		30. Name and address of person who completed cause of deeth (Itam 23a) (Type, Print)	2.2.5		1011	
		DAVID FROMS M.D. 4191 MOUNTAIN	RD, PAS,	MAGNY	MD 7	117.7
Sta	te	31. Data filed (Month, Dey, Year) 32. Registrar's Signeture	, , , , , , ,	., ., .,	1	1100
Pogleti		OCT 0 9 1007				



		A Party down At 11 Jan 1 1 Am			0011	tificate of	Doutin		Reg. No.		
Physici	an	1. Decedent's Nama (First, Middle, L						2. Date of De Month	Day	Year	Time of Death
/Medi	cal	4a. Facility Nama (If not institution, g	Sallie				4b. City, Town, or L	OCT Doest		1997 1,	75 1111
Examir	ner	4a. Facility Nama (il not instributori, g	1		4	. \					4
		5. Social Security Number 6.		1800		If Under 1 Yaa	Baltimore If Undar 24 Hrs.			nore Ci	
uneral irector		213-24-1932	10 M 20 F 6		Yrs.	Months Day		8. Date of Bird (Month, Da Aug. 5	y, Year) 1932	Country) Mary	(State or Foreig
		Usual Rasidence of Decedent						1106.5	1752	italy	Tand
T T		10a. Stata 10b. County		10c. City, To	own or Loc	ation					nside City Limits
1	cto		more City	Balt	imore	2				1	Yas 2□No
0 0	Die	10e. Street and Number				10f. Zip Coda			10g. Citizen of V	Vhat Country?	
23	Funeral Director	4800 Seton Dri				2121			U.S.A		
De la	nue	11. Maritai Status	12. Was Decedent Armed Forcas	?	13. W	as Decedent of Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yas or No Rican, etc.)	- 14. Rac Biad	e - Amarican Ind k, Whita, etc.	dlan,
"natural", or items 23s or 28s-f show officed Examiner rount be notflied at	ρ	1 Never Married 2 Married 3 Widowad 4 Divorced	1 ☐ Yes 2 ☑ If Yas, Give Year or Datas:	No	1	☐Yes 2☑Ne	o Specify:		Specify	Black	
Diese Charles	etec	15. Decedant's in (Specify only highest g	Education rada complated)	1	(Giva k	ant'a Uauai Occi	a during most of work	ina	16b. Kind of Bu	usiness/Industry	1
arked other than " atic event, the Me	Completed	Elementery/Secondery (0-12)	Coilega (1-4or	5+)	lifa. D	O NOT use retir known	red)		unkno		
A Par		8 17. Father's Name (First, Middla, Las	0		un	KIIOWII	40 Matt and Manual	a /Final Adiabata			
tem 27 is marked other than "natur other treumatic event, the Medical	To Be	James Salliey	н				18. Mothar's Nam Mary Co		Maldan Suman	ie)	
Is me		19a. Informent's Name/Raiationship	(Type, Print)	1	9b. Mailing	Addrass (Street	et and Number or Rui	ral Routa Numb	er, City or Town,	State, Zip Code	a)
other tre		Elverta Salliey	/sister		3001	Westwo	od Avenue,	Baltim	ore, Ma	ryland	21216
		20a. Mathod of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 4 ☐ Donation 5 ☑ Othar (Spec	□Ramovai from Stata	ceme	of Dispos ete <i>ry, cre</i> m	ltion (Nama of atory or other pi	/ace)	Data	20c. Location -	City or Town, S	State
Amportant: If any injury or once.		23a. Ranti. Entar tha disaase, or co	mpilcations that cause	d the death. D	Ва	Itimore	ress of Facility tomy Board , Maryland ving, such as cardiac	21201			
sician edicai iminer	e.	immediata Causa (Final diseasa or condition rasulting in death)				-	MCINON	IA OF	BRAII	Ons	roximate val Between et and Death
physician and s the burial-transit	Examiner	Sequentially list conditions,	b	Dua to (or es	e consequ	ance ot):					
buria	ical E	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c							i	
attanding physic d for usa as the b		that initiated avants rasulting in death) Last	l d	Dua to (or es	e consequ	ance ot):					
the attan	Physician/Med	Part II. Other significant conditions	contributing to death b	out not resultin	g in tha un	darlying causa ç	jivan in Part I.	23b. Dld	tobacco use co	ntribute to the	cause of death
igned by the be detached	by Ph	HX of SEIZUM	E DISOR	CDER				10	Yes 2□ No	3 Probably	4 Donknow
peen s	Completed								an autopsy med?	availabia	utopsy tindings a prior to tion of causa
ate has page 2	E O							10	ras 2 No	1 □ Yas	2 □ No
	40	25. Was casa ratarred to medical					26. Place of Dea	th (Check only o	ona)		
0 0	ToB	axaminar? 1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpati	ant 2 ER/	Outpatient	3□ DOA C			dance 6 Oth	ar (Specify)	
After th funaral		27. Menner of Deeth 1 ☑Natural 5 ☐ Panding	28a. Data of Inju	iry 28l	b. Tima ot Injury	28c. Inj			now injury occur		
y the	Certification:	2 Accident invastigati 3 Suicide 6 Could not	be and Blood of In	iury - At homa		M 1[	□Yas 2□No	28f. Location (	Street and Numb	er or Rural Rou	ıta Number,
To the Funeral Director: A completely filled in by the fi		4   Homicida	building, e	c. (Spacify)				City or To	vn, Stata)		
aly f	edical	29a. Cartiliar (Check only one)	hysician: To the best miner: On the basis o and manner st	t examination	ige, deeth and/or inva	occurred et tha astigation, in my	time, deta and piece, opinion, deeth occur	end dua to the red at the time,	cause(s) end me date and plece,	enner es steted. end dua to tha c	cause(s)
Set	4		and maintai si	oted.							

State Registrar

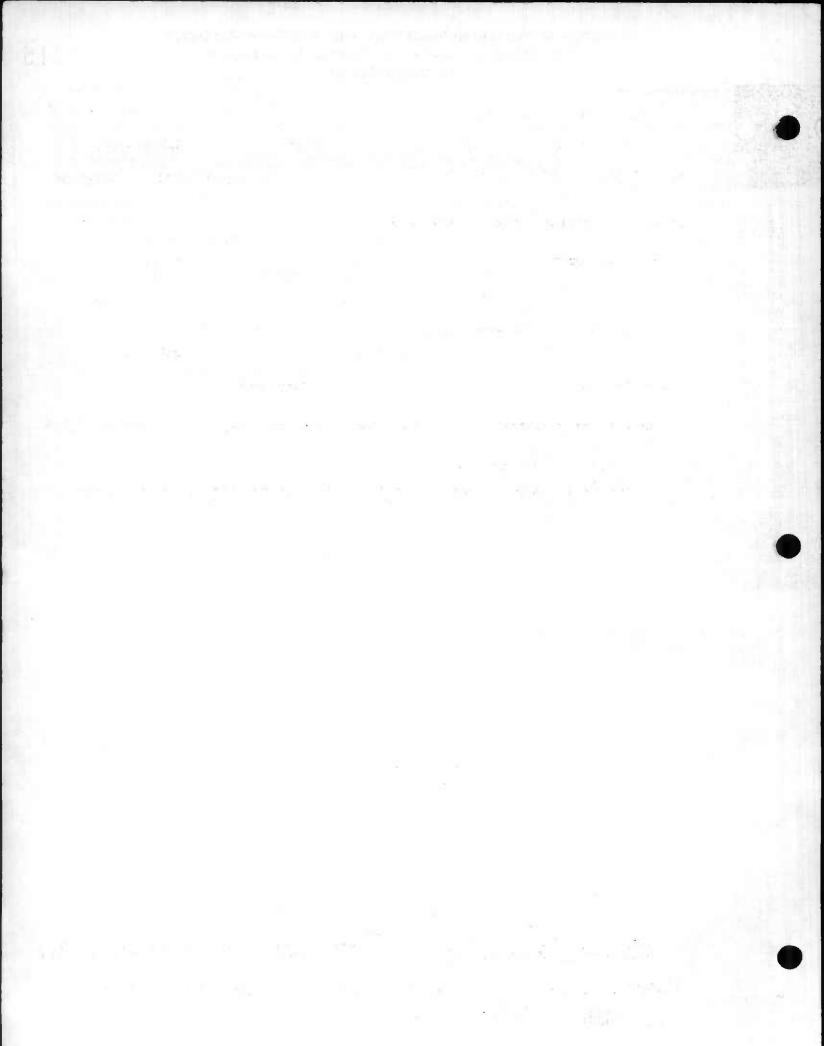
30. Nama and addrass of parson who completed cause of death (Item 23e) (Type, Print)

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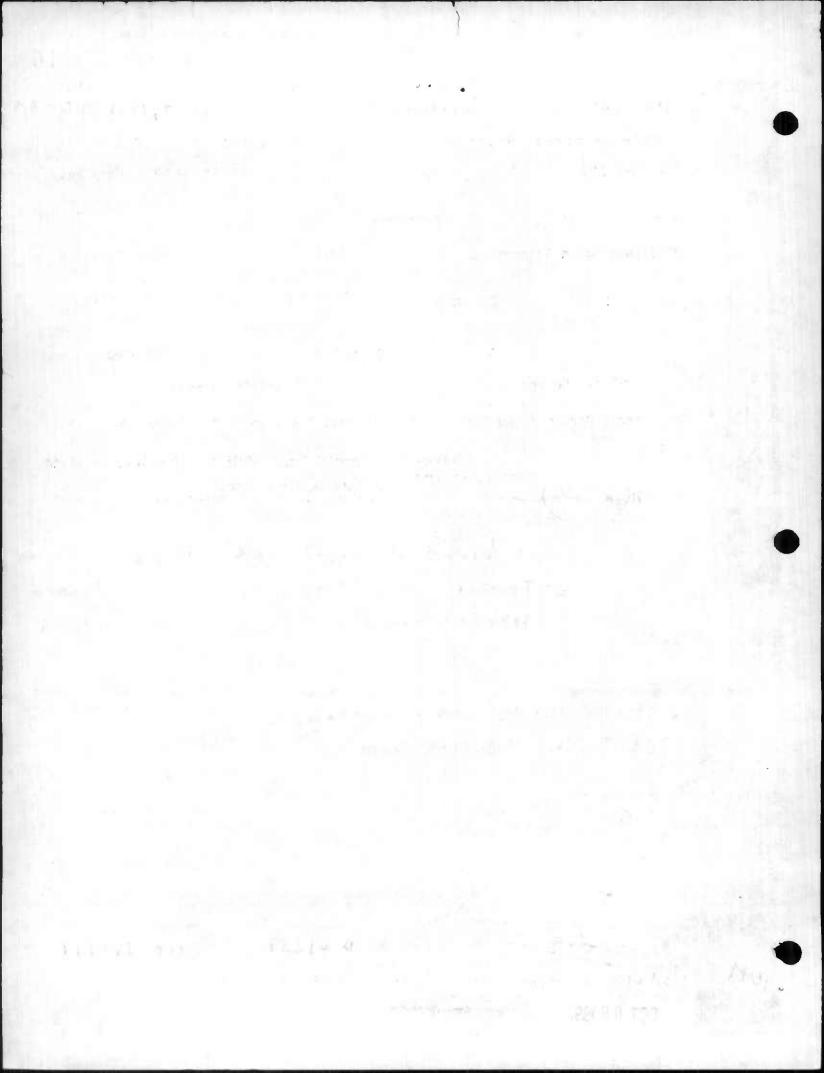
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State of Maryland / Department of Health and Mental Hygiene 97

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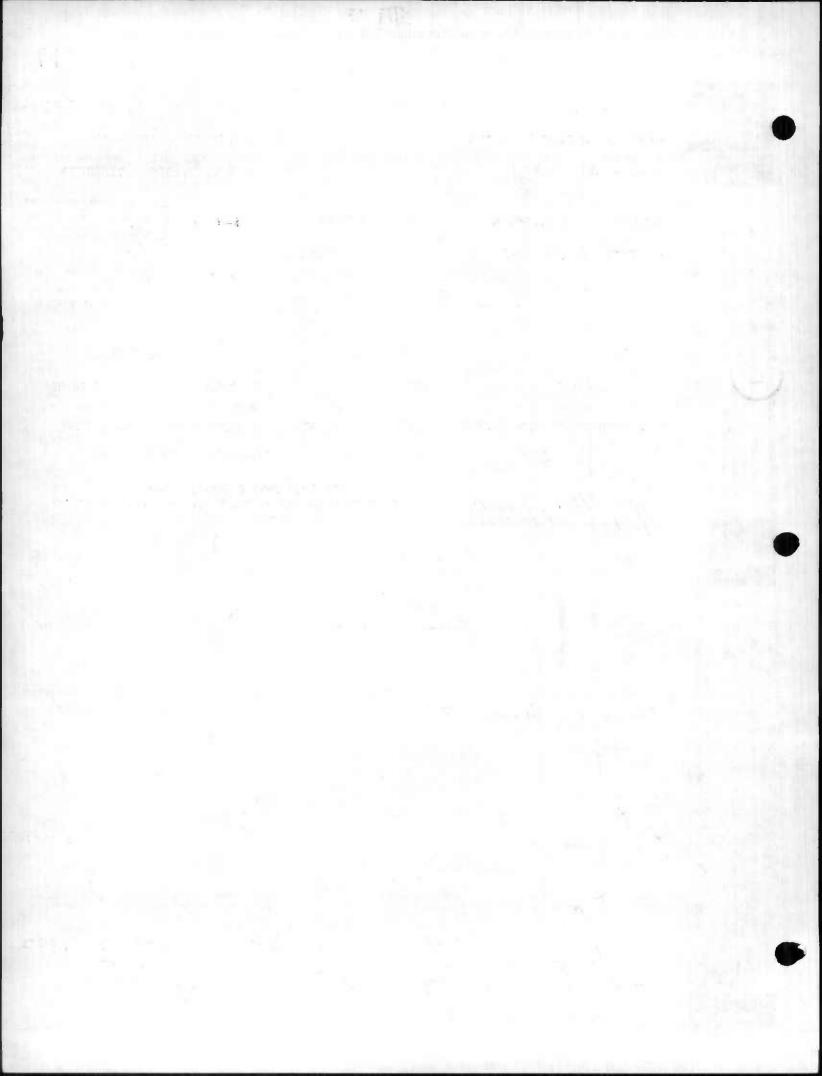
	ve street end number)  i al Hospit  Sex 7. Age (h	al n yrs. last birthday, 73 Yrs. c. City, Town or L. Baltim	If Under 1 Year Months Deys		more	P 7 1 4c. County	N / A  9. Birthple Countr	3. Time of Deeth  9:50  acc (State or Foreign y)  yland
Union Memor  Union Memor  S. Sociel Security Number  216-16-9414  Usuel Residence of Decedent  10a. Stete 10b. County  Maryland N/A  10e. Street and Number  2217 Huntingdon  11. Marital Stetus  1 Never Married 2 Married  3 Widowed 4 Midworced	ial Hospit Sex 7. Age (In 10 M 200 F )  Avenue	73 Yrs.	If Under 1 Year Months Deys	Baltir If Under 24 Hrs.	October ocation of Deeth more	4c. County	997 y of Deeth N / A 9. Birthple Countr	ace (State or Foreig
Union Memor  5. Sociel Security Number 216-16-9414  Usuel Residence of Decedent 10a. Stete 10b. County  Maryland N/A  10e. Street and Number 2217 Huntingdon  11. Marital Stetus 1 Never Married 3 Widowed 4 Midvorced	ial Hospit Sex 7. Age (// 1 M 2 X F 7. Age (// Avenue	73 Yrs.  Oc. City, Town or L	Months Deys	Baltir If Under 24 Hrs.	more	4c. County	N / A  9. Birthple Countr	ice (State or Foreigr y) yland
5. Sociel Security Number 216-16-9414  Usuel Residence of Decedent 10a. Stete 10b. County  Maryland N/A 10a. Street and Number 2217 Huntingdon 11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Midvorced	Sex 1 M 2 X F 7. Age (II	73 Yrs.  Oc. City, Town or L	Months Deys	If Under 24 Hrs.	more 8. Dete of Birth (Month, Dey) 11/30/		9. Birthple Countr	oce (Stete or Foreign y) yland
216-16-9414  Usuel Residence of Decedent 10a. Stete 10b. County  Maryland N/A  10e. Street and Number 2217 Huntingdon  11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Mid-Divorced	Avenue	73 Yrs.	Months Deys		8. Dete of Birth (Month, Dey 11/30/	1923	9. Birthple Country Mary	ce (Stete or Foreigr. y) yland
Usuel Residence of Decedent 10a. Stete 10b. County Maryland N/A 10e. Street and Number 2217 Huntingdon 11. Maritai Stetus 1 Never Married 2 Married 3 Widowed 4 Midworced	Avenue	c. City, Town or L			11/30/	1923	Mary	yland
Maryland N/A  10e. Street and Number  2217 Huntingdon  11. Marital Stetus  1 Never Married 2 Married  3 Widowed 4 M Divorced	Avenue							
10e. Street and Number  2217 Huntingdon  11. Marital Stetus  1 Never Married 2 Married 3 Widowed 4 Midoword	12. Was Decedent Eve	Baltim	ore				100	d. inside City Limits
2217 Huntingdon  11. Marital Stetus  1 Never Married 2 Married 3 Widowed 4 Midoword  15. Decadent's E	12. Was Decedent Eve							1 X Yes 2 □ No
1. Maritai Stetus  1 Never Married 2 Married  3 Widowed 4 Morroced	12. Was Decedent Eve		10f. Zip Code		1	I0g. Citizen of \	Whet Countr	y?
1 Never Married 2 Married 3 Widowed 4 MDivorced  15. Decadent's E	12. Was Decedent Eve		212	11		Unite	ed Sta	tes
3 ☐ Widowed 4 🏿 Divorced	Armed Forces?	r in U,S. 13.	Was Decedent of if Yes, specify Cub	Hispenic Origin? (Spoen, Mexicen, Puerto	ecify Yes or No- Ricen, etc.)		ce - Americer	
15, Decadent's E	1 XYes 2 No If Yes, Give	NA TT	1 ☐ Yes 2 🕱 No	Specify:		Specify		
(Specify only highest gr		W II	dontio Housel Occur	- ation				
	ede completed)	(Give	dent's Usuel Occu kind of work done DO NOT use retire	petion during most of work ed)	ing	16b. Kind of Br	usiness/indu	stry
Elementery/Secondery (0-12)	College (1-4or 5+)		Homemake			Own	Home	
7. Fether's Neme (First, Middle, Last	)		- Tomoman	1	e (First, Middle, i			
William Do	rsey			Nel1	ie Hoen	sch		
			ng Address (Stree	t end Number or Rur	al Route Number	, City or Town,	Stete, Zip C	ode)
				ill Avenue	Bal	timore,	Md.	21206
		Ob. Pleca of Dispo cemetery, cre	osition (Neme of metory or other ple	ice)	Date	20c. Location -	City or Tow	n, Stete
4 ☐ Donetion 5 ☐ Other (Specif	(y)	Dulaney Val	ley Memori	al Gds.	10/11/97	Timoni	um, Ma	aryland
mmediate Ceuse (Finel diseese or condition	a. RUPTU	RE D	er the mode of dyi	G THORAC	or raspiretory arm	est,	KYSM	21214 Approximate Intervel Between Donset end Deeth  5 Min Je WEEKS
Sequentially list conditions,	Due	to (or es a consec	quence of):		311			WECKO
cause. Enter Underlying Ceuse (Disease or Injury	. HYPER	SLEN.	SION				10	YEARS.
net initieted events	Due	to (or es e conseq	uence of):					
	d							
art II. Other elanificant conditions o	antification to double but an	A			Ont. Plate			
								ne cause of death? bly 4 ☐ Unknown
י הוונפטי	CHIVE CL	1/40-	DIZEAT	E,	10	20140	0,11000	ory 4 Donalow
OLR PHERA	VALCU	LAP N	` A.		24e. Wes e	n eutopsy		autopsy findings able prior to
PERTITION INCIDENT	c vioco	LITIN D	17541	<u> </u>	ponon	1001	comp	pletion of cause
					1 □ Ye	s 2 No	101	Yes 2□ No
Wes case referred to medical exeminer?					n (Check only on	Θ)		
1 ☐ Yes 2 No	1 Inpatient		I 3L DOA	4 LI Nursing Ho	me 5 Reside	nce 8 Oth	er (Specify)	
1 Naturel 5 ☐ Pending		ar) 28b. Time of injury			28d. Describe ho	w Injury occurr	red	
T 1 100100111	9							
4 ☐ Homicide determined	building, etc. (S	At nome, term, str pecify)	eet, ractory, offica		City or Town	reet end Numb i, Stete)	er or Hurei F	loute Number,
9a. Certifier the Certifying Ph	yeician: To the best of my	knowledge deeth	cooursed at the time	me data and slace	and due to the co			
(Check only 2 Madical Exam	ninar: On the basis of exe and menner steted.	minetion end/or Inv	estigetion, in my	plnion, deeth occurr	ed et the time, da	ate and pleca, o	end due to th	ed. ne cause(s)
						Od Data :	d /Month Do	W Voort
9b. Signeture end title of certiling			29c. Licens	e number	2	9d. Dete signed	a (Month, De	y, 708/)
9b. Signeture end title of certifier			29c. Licens	►1637	2.			
D. Neme and address of person who	completed cause of death	(item 23a) (Type.	DU	+1637	2	OCT		997
D. Neme and address of person who	completed cause of death	(item 23a) (Type,	Print)	+1637	nstjital	OCT		
	William Do  19e. Informent's Neme/Reletionship of Mrs. Bonnie Parki  20e. Method of Disposition  1	20e. Method of Disposition  1 M Buriei 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)  21. Signeture of Funerei Service Licensee Mark T. Z.  23e. Pert 1. Enter the disease, or contributions that caused the shock, or heert teilure. List only one ceuse on each line.  Immediate Ceuse (Finel disease or conditions fresulting in deeth)  Sequentielly list conditions, fresulting in deeth)  Sequentielly list conditions, fresulting in deeth)  Due  Couse (Disease or injury that initiated events resulting in deeth)  Cert II. Other significant conditions contributing to death but not consider the sequence of the	William Dorsey  19e. Informent's Neme/Reletionship (Type, Print)  Mrs. Bonnie Parkin / Daughter  20e. Method of Disposition  10d Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)  21. Signeture of Funerel Service Licensee Mark T. Zavoyna 22. Pert 1. Enter the disease or combilications that caused the death. Do not entered to medical cause. Enter Underlying Cause (Disease or Injury het initiated events resulting in deeth) Lest  25. Wes case referred to medical exeminer?  1 Yes 2 No  19b. Mailit 462  20b. Pleca of Disposition 10d Buriel 2 Coremetion 3 Removel from State 20b. Pleca of Disposition Coremetery, cre Dulancy Val 21. Signeture of Funerel Service Licensee Mark T. Zavoyna 22. Avoyna 23. Pert 1. Enter the disease or conditions that caused the deeth. Do not entered to ease or condition resulting in deeth. Do not entered to ease or condition resulting in deeth. Do not entered to great injury that initiated events resulting in deeth)  25. Wes case referred to medical exeminer?  1 Yes 2 No  26. Wes case referred to medical exeminer?  1 Yes 2 No  27. Manner of Death 28. Pleca of Injury At home farm strength.	William Dorsey  19e. Informent's Neme/Reletionship (Type, Print)  Wrs. Bonnie Parkin / Daughter  20e. Method of Disposition 10 Buriei 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify)  21. Signeture of Funerei Service Licensee Mark T. Zavoyna 22. Name end Addre Leonard 23e. Pert 1. Enter the disease or conditions on the caused the deeth. Do not enter the mode of dying shock, or heert tellure. List only one ceuse on each line.  23e. Pert 2 Cause (Finel disease or conditions resulting in deeth)  25e. Sequentielly list conditions, if eny, leading to immediate ause. Enter Underlying Cause (Disease or injury healt inflied events resulting in deeth) Lest  25e. Wes case referred to medical exeminer?  25f. Wes case referred to medical exeminer?  26f. Wes case referred to medical exeminer?  27f. Manner of Death 27	William Dorsey   Ne1    19e. Informent's Neme/Reletionship (Type, Print)   19b. Mailing Address (Street end Number or Runder's Bonnie Parkin / Daughter   4622 Greenhill Avenue   4622 Greenhill Ave	William Dorsey   Nellie Hoen:	William Dorsey   Nellie Hoensch     19e. Informent's NemerReletionship (Type, Print)     19e. Informent's NemerReletionship (Type, Print)     19f. Mailing Address (Street end Number or Rural Route Number, City or Town     19f. Mailing Address (Street end Number or Rural Route Number, City or Town     4622 Greenhill Avenue   Baltimore,     20e. Method of Disposition   Section   Section     10f. Buris   Section   Section   Section   Section   Section     10f. Buris   Section   William Dorsey   Nellie Hoensch	



State of Maryland / Department of Health and Mental Hygiene 0.7

Physicia		1. Decedent's Neme (First, Middle, Las			^			2. Dete of Dee	th Day	3. Year	Time of Death
/Medica	_	GEOR6	E 3	SEN	TER			OCT	4 1	999	8:00 Pm
Examine	_	4e. Fecility Neme (If not institution, give					4b. City, Town, or L		4c. County		
	Ц	NORTHWEST HOSPIT						ALLSTOWN		IMORE	
Funeral Director		5. Social Security Number 6. Social Security Number 1  231–26–4949 1  Usual Residence of Decedent	7. A	ge (In yrs. Ia 68	Yrs.	Months Deys		8. Dete of Birth (Month, Det NOV • 8	, 1928	9. Birthpiece (Country) VIRGIN	State or Foreign
W 20	-	10e. Stete 10b. County		10c. City,	Town or Loc	cation				10d. In	side City Limits
23a or 28a-f show ust be notified at	10	MARYLAND BAL	TIMORE		RANI	DALLSTOW	N			3	Yes 2 No
or 28	S S	10e. Street end Number				10f. Zip Code			log. Citizen of V	What Country?	
23a data	<u>a</u>	103 FITZ CT. APT	. T-3			21	136		Ţ	JSA	
al', or items Examiner in	by Fur	11. Maritai Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorcad	12. Was Decedent Armed Forces? 1 Z Yes 2 If Yes, Give Yeer or Detes:		i. 13. V	Vas Decedent of Yes, specify Cul ☐ Yes 2 🛣 No	Hispenic Origin? (Spen, Mexican, Puerlo Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Rac Bled Specify	e - American Indek, White, etc.	dien,
alcal.	Completed	15. Decedent's Ed (Specify only highest gree	ucation		18e. Deced	ent's Usuei Occu	petion	kina	16b. Kind of Bu	usiness/Industry	
a Mes	d d	Etementery/Secondary (0-12)	Cottege (1-4or	5+)			during most of worked)	ving .			
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	0	19e. Informent's Name/Relationship (7	ima Brintl	۱۱۲۸		n Addrona (Ctana	t end Number or Ru		Cit. or Town	SAND	
27 is m traum		MRS. MAUREEN SEN		. 1					and the last		
f Item 27 I		20e. Method of Disposition		20h Pie	ace of Dispos	ition (Neme of	ATP. T-3	Dete		City or Town, S	
y or		1 Buriai 2 □ Cremetion 3 🔀 4 □ Donetion 5 □ Other (Specify		Cel	FORES	etory or other ple T LAWN	10	-7-1997	NORFOL	K, VA	
important: If item 27 is any injury or other tra		21. Signature of Funerel Servica Licens			22.	Neme end Addr	ess of Fecility				
impour any ir	4	1 ( Lu Alan	Lavis		0.0		Levinson				
	+	23a. Pagf. Enter the disease, or cooperathock or heart failure. List only o	lications that cause	d the deeth.	Do not ente	OO Reis	terstown Ing, such es cardiec	Road Pik or respiretory are	esville	MD 21	.208 Toximate vai Between
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physician and s the bunal-transit	Yal	Sequentially list conditions, if env. leeding to Immediate			es Consequ					0	
buria	2	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Sevi	ue	PUD				2	year 3
g physicia as tha bur	5	resulting In deeth) Last		Due to (or e	es e consequ	enca of):					
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		CAD						24a. Wes e perfor		aveileble	ion of cause
2 should	-							1 □ Y	es 2 No	1 ☐ Yes	2 No
hes 3 e 2	5										
hes 3 e 2		25. Wes case referred to medical					26. Place of Dee	th (Check only or	10)		
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ALBERT			State	of Ma				lealth and I	Mental Hy	giene 9	7 :	30618
SCHNEIDE	ERM	AN				Certif	icate of	Death		Reg. No.		
Physic	ian	Decedent's Name (First, Middle	e, Last)						2. Date of De Month	ath Day	Year	3. Time of Deeth
/Medi		ALBERT			SCH	NEIDE	ERMAN		OCTOBER	-	1997	5:33P.M.
Exami	ner	4a. Facility Name (If not institution	n, give street and n	umber)				4b. City, Town, or I	ocation of Death		ty of Death	
		SINAI HOSPITAL		T			Under 1 Year	BALTIM	ORE	N/	T	
Funeral Director		5. Social Security Number 217–12–0936	6. Sex 1 M 2 □ F	7. Ag	e (In yrs. last birtl 74 Y		onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da DEC. 28	y, Year) 3,1922	Cou	plece (State or Foreign ntry) R <b>YLAND</b>
pu .		Usual Residence of Decedent  10a. State 10b. County			10c. City, Town	or Location	on.				T	10d Ionida Olbu Limita
death with the Maryland ms 23a or 28a-f show	ctor	MARYLAND BALTI	MORE		Too. Only, Town	OI LOCAIN		LLSTOWN				10d. Inside City Limits 1 X Yes 2 No
23a or 28	I Directo	10e. Street and Number	DOAD			1	0f. Zip Code 21133			10g. Citizen o	What Cou	ntry?
urs after death with al', or items 23a or	Funeral	4013 STARBROOK  11. Marital Status	12. Was De	cedent I	Ever In U.S.	13. Was		lispanic Origin? (Si	pecify Yes or No			icen Indian,
after deal or items		1 Never Married 2 XMarr	Armed F					lispanic Origin? (S <sub>i</sub> an, Mexic <i>e</i> n, Puert	Rican, etc.)	В	ack, White	
ours a	by	3 ☐ Widowed 4 ☐ Divorced	if Yes, C Year or	Bive Dates:		1 🗆	Yes 2 No	Specify:		Spec	ity:	WHITE
72 hours	etec	15. Decedent (Specify only highes	's Educetion	()	16a. I	Decedent'	s Usuai Occup	ation during most of world)	kina	16b. Kind of	Business/Ir	ndustry
filed within Hygiene.	Completed	Elementary/Segozdery (0-12)		(1-4or 5	+)		AGER-OW			GA	SOLIN	E STATION
e d ala	To Be C	17. Fether's Neme (First, Middle, LOUIS	Last)	5	SCHNIDER	MAN		18. Mother's Nan ED	ne (First, Middle, ITH	Maiden Suma	unkn	OWN
nd 2 sith er trau		19a. informant's Name/Relations MRS. HELEN SCHN		/ /		_		and Number of Ru K ROAD R				
Peges 4 en mant of Hee		20a. Method of Disposition 1	2 Dameuri from	- Ctata	20b. Piace of cometery	Dispositio	n (Name of ry or other plac	ce)	Date	20c. Location	- City or T	own, State
and and and and and and and and and and		4 □ Donetion 5 □ Other (S)	ecify)	n State	RIGA	A KUR	LANDER	VEREIN	10-7-19	97 ROSE	EDALE	MD
permit. Peggs-1 Department of H Japontant: If its any Injury or ot		21. Signature of Funeral Service	Licensee	)					& Bros.	Inc.		
Physician		23a. Pagr. Enle the diseese, or shock, or heart failure. List	complications that only one cause on	caused each iir	the death. Do no	ot enter th	e mode of dyin	g, such es cerdiac	or respiretory e	rrest,		Approximete interval Between Onset and Death
/Medical		Immediate Cause (Final disease or condition	Mul	tiol	· Time	10-						
Examiner		resulting in deeth)	θ.	1	e Injur Due to locas e co	onsequen	ce of):					name of the second
p is	aminer		<b>—</b> b									
Den January III	X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0		Due to (or es a co	onsequen	ce of):					
eo y	Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last	d		Due to (or as a co	onsequenc	ce of):					
equires that the death ce een signed by the ettendii rould be deteched or use		Pert ii. Other aignificant condition	na contributing to	deeth bu	ut not resulting In	the under	tying ceuse giv	en In Part i.		tobacco u <i>e</i> e o Yes 2□ No		to the cause of death?
equires 1	ted by								24a. Was	an autopsy	24b. W	ere autopsy findings valiable prior to

Division of Vital Record this certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I

Be Comple Medical Certification: To

completion of ceuse of death? 1 Ves 2□No 192 Yes 2□ No 25. Was cesa referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2□ No 28d. Describe how injury occurred motor vehicle accident 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending investigation injury 10-5-97 1535 p 1 Yes 2₽No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Aural Route Number, City or Town, State) & 5. Dolfield Clud 4 Homicide

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, dete and place, end due to the ceuse(s) and manner stated.

O.C.M.E.

29b. Signeture end title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

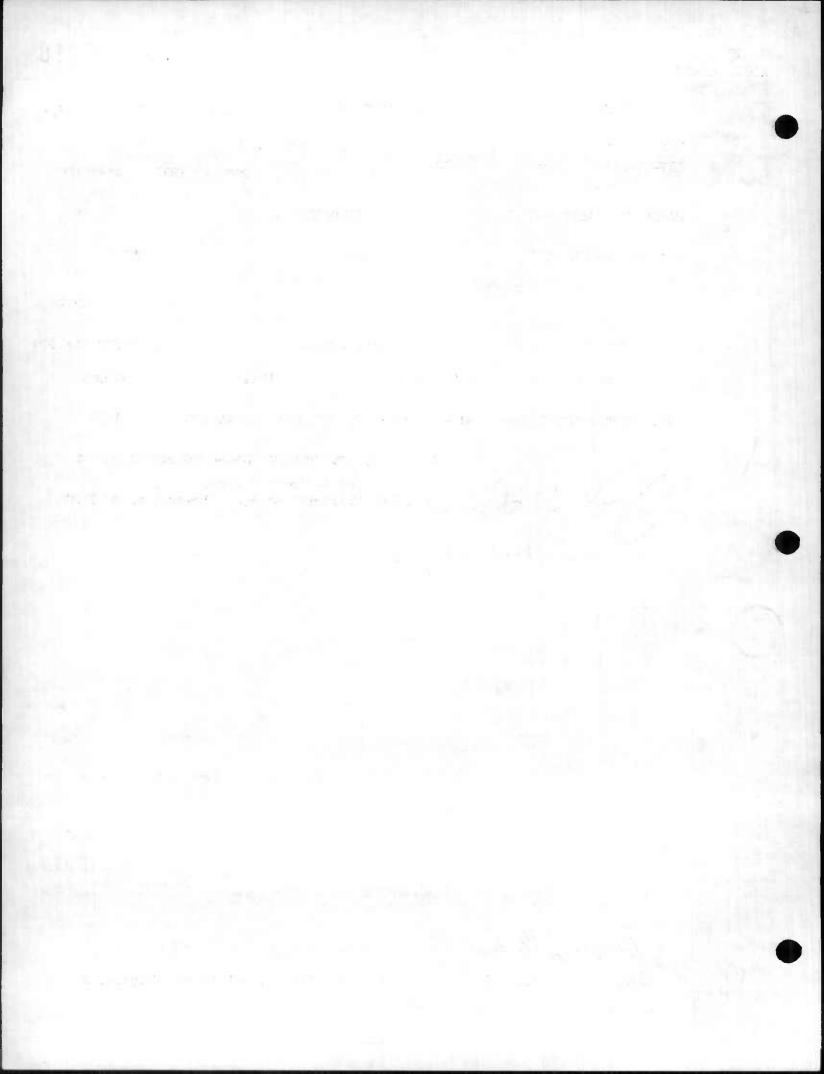
Dennis J. Chute, up 11.

111 Penn Street, Baltimore, Maryland 21201

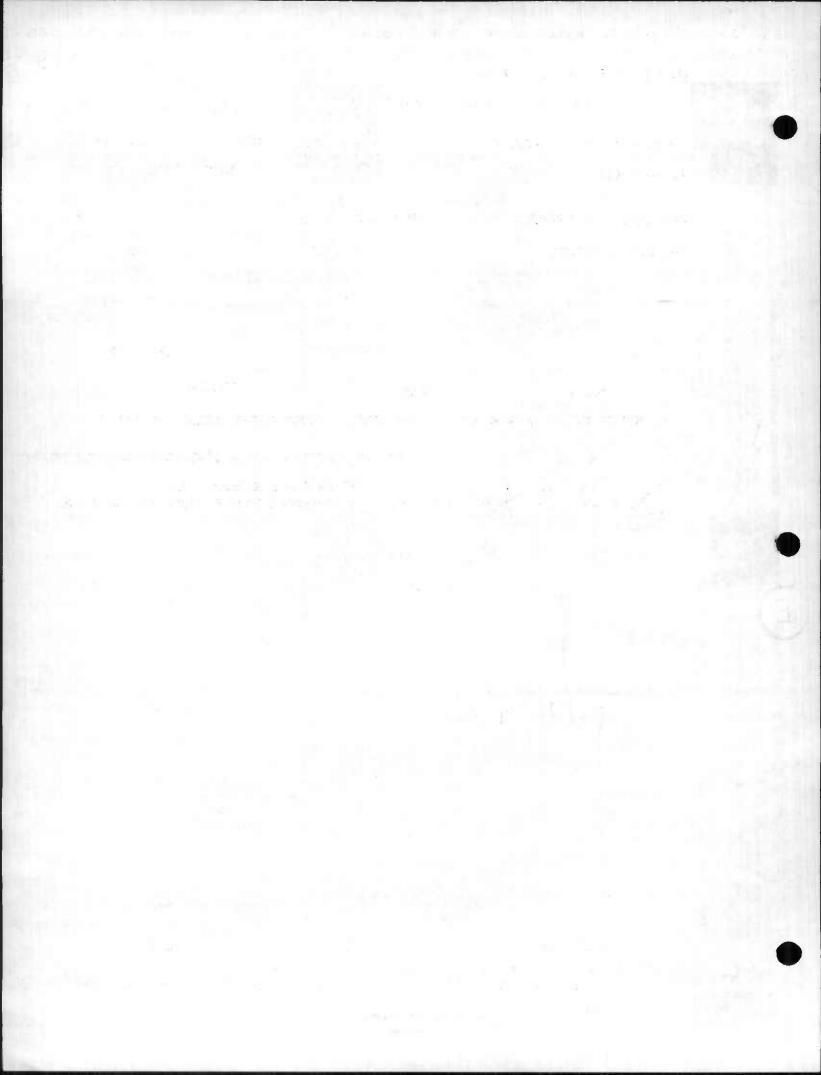
OCTOBER 6, 1997

State Registrar

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cian lical	Decedent's Name (First, Middla, LILL	IAN LI		ILVER			2. Date of Death Month OCT. 5,	Day 1997	Year	3. Tim 22 th
iner	4a. Facility Name (If not Institution, g		r)			4b. City, Town, or Lo		4c. County		
	8 SIERRA CIRCLE 5. Social Security Number 6		ige (In yrs. last birt	hday) If Under		OWINGS MI If Undar 24 Hrs.	8. Date of Birth	BA	9 Birtho	RE lace (State or Fora
	220-07-0411	1□M 2√F	mm	rs. Months	Days	Hours Min.	JUNE 6	,1920	NEW	YORK
	Usual Residence of Dacedent  10a. Stata  10b. County		10c. City, Towr	or Location					11	Od. Inside City Limi
tor		IMORE		INGS MIL	LS				} "	1√2 Yes 2 □ N
lrec	10e. Street and Number			10f. Zip			10	g. Citizen of V	Vhat Coun	try?
rai	8-B SIERRA CIRCL	E			211	17		US	SA	
by Funeral Director	11. Maritai Status  1 ☐ Never Married 2 ☑ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Yes 20 If Yes, Give Year or Dates	3? } No	13. Was Deced If Yes, speci	ify Cube	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yas or No- Rican, etc.)	Blac	e - America k, White, o	etc.
ted	15. Decedent's	Education		Decedent's Usua	Occup	ation	. 1	6b. Kind of Bu		
Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4o	5+)			duning most of work	ing			
	17. Fathar's Name (First, Middle, La	st)		HOUS	EMT	18. Mother's Name	a (Firet Middle N	OWN I		
To Be	MEYER	01)	WIN	<b>2</b> D		TO. MIOCHEL S HAMI	UNKNOW		10)	
-	19a. Informant's Name/Relationship	(Type, Print)			(Streat	and Number or Run			State, Zip	Code)
	MR. JOSEPH SILV	ER / HUSBA				IRCLE OWI				
	20a. Method of Disposition		cameter	Disposition (Nam	her plac			Oc. Location -		
	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice			22. Nama and		DRIAL PAR	K - 10+7	-199/-	KANDA	LLSTOWN,
	0	o L	5 -	So	1 Le	evinson &				21208
ai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. A	Due to (or as a c	onsaquenca of):	)					minute,
Physician/Medical	rasulting in death) Last	d	Due to (or as a c	onsequence of):						
sici	Part II. Other significant conditions	contributing to death	but not resulting in	tha underlying ca	use giv	en in Part I.	23b. Did tot	acco uae con	ntribute to	the ceuse of dear
	Diale	te mel	letus				1□ Ye	8 2 No	3 Prob	ably 4 Unknown
Completed by							24a. Was an		ava	re autopsy finding illable prior to npietion of cause leeth?
E O							1 ☐ Ye	s 2thro	1 🗆	Yas 2 No
Be	25. Was casa referred to medical examiner?				Lau		h (Check only one	)		
: To	1 ☐ Yes 2 ☐ No 27, Manner of Death	Hospitai: 1 Inpai				4 Li Nursing Ho	ma 5 Rasider 28d. Describe hor	nce 6 Oth		)
Certification:	1 Natural 5 Pending 2 Accident investigate 3 Suicida 6 Could not	he		М		Yes 2□No				
-	4 Homicida determine	building, e	njury - At home, far tc. <i>(Specify)</i>				28f. Location (Str. City or Town,	Stata)		
edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exc	Physicien: To the basis eminer: On the basis and mannar s	of examination and	daath occurred a /or investigation,	it tha tim in my o	ne, date and place, pinion, daath occurr	and due to the ca red at the time, da	usa(s) and ma ta and placa, a	nnar as stand dua to	ated. the causa(s)
	29b. Signature,and title of certifier.	D		29c.	License	e number	29	d. Data signa	d (Month, L	Day, Year)
ž	and any and a second									
	▶ Gosep/)	Teamb			D10	034		10/64	()	



State of Maryland / Department of Health and Mental Hygiene 97

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Year MARGARET SCALL Y OCT 12:27 PMI HELEN F0 97 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner GOOD SAMARITAN HOSPITAL BALTIMORE CITY N/A If Under 1 Year If Under 24 Hrs.
Months Devs Hours Min. 5. Sociei Security Number 6 Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 Ø F Deys Yes. Director 212-05-0027 80 MARYLAND Usuai Residence of Deceden 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No rms 23a or 28a-f s r must be notified Director BALTIMORE TOWSON 10e. Streef and Number 10f. Zip Code 10g. Citizen of Whet Country? Berns 23s 1706 WESTON AVENUE 21234 USA Funeral 11 Maritei Status 12. Wes Decedenf Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Merried 6 1 Yes 2√ No Specify: Specify: þ 3 DWidowed 4 □ Divorced WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HUTZLERS BELL Elementery/Secondery (0-12) Coilege (1-4or 5+) TELEPHONE. 12th GRADE SWITCHBOARD OPERATOR 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be P THOMAS J. O'NEILL UNAVAILABLE FITZPATRICK 19a. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 27 PATRICK J. SCALLY SON 2810 BERWICK AVENUE BALTIMORE, MD 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE NATIONAL CEM. 10/10/97 BALTIMORE, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. lutall 23a. Pert1. Enter the diseese, or complications ther caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Onsef end Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) SEPTIC 5 HOURS SHOCK Examiner Due to (or es e consequence of): CELLULITIS Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of) physician s the burial Box 68760 Physician/Medical Due to (or es e consequence of) o P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 20 No 3 Probably 4 Unknown Hypertension, Diabetes mellitus Records. by 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 2 No 1 ☐ Yes Mo certificate Division of Vital 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatienf 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2√ No 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred of or Attending P sefer death. Certification: 28e. Date of Injury (Month, Day Year) 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigetion 3 Sulcide 6 Could not be 28e. Piece of Injury - At home, farm, streef, facfory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted. 29a. Certifier Medical (Check only one) 29b. Signature end fifie of certifier 29d. Date signed (Month, Dey, Year) 29c. License number papele no. Oct, 7, 1997. P 11390 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

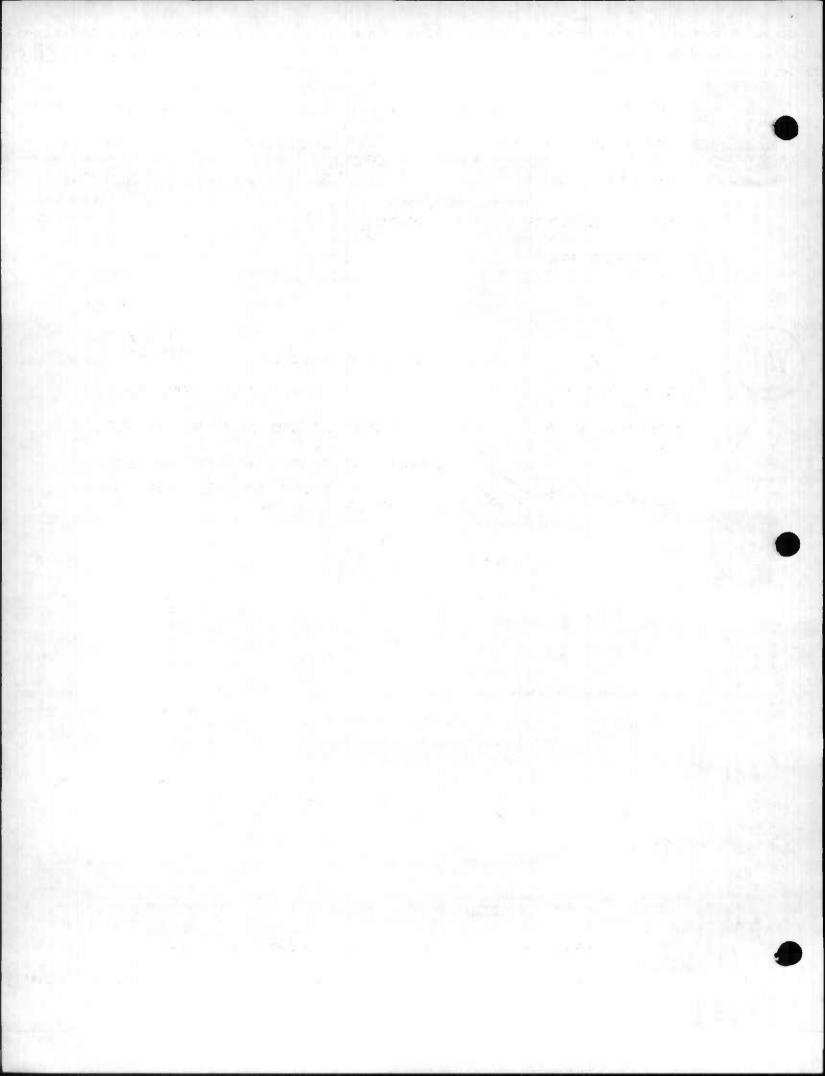
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BALTINORE, NO 21239



State of Maryland / Department of Health and Mental Hygiene 97 30621

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/Medical Examiner	ľ	la. Facility Name (If not institu			er)				4b. City, Town, or L	ocation of Deat			, , , , , , , , , , , , , , , , , , , ,
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State of Maryland / Department of Health and Mental Hygiene 9 7 3

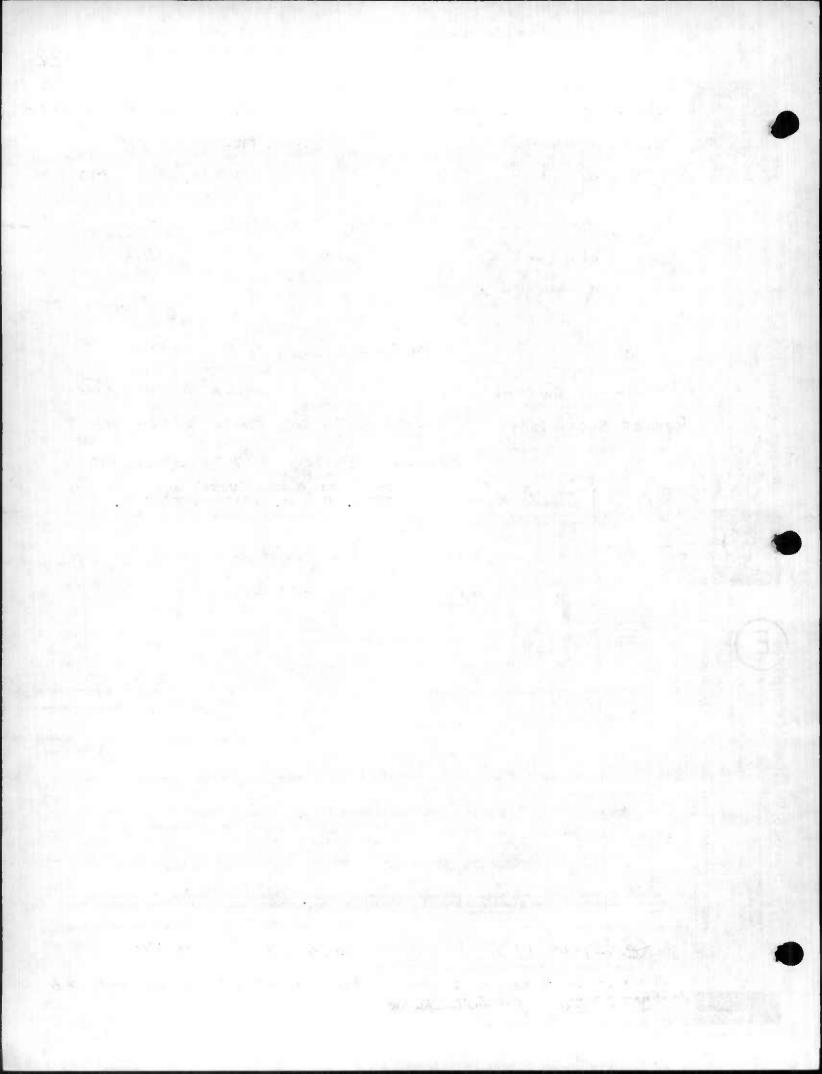
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 4e. Fecility Neme (If not institution, give street end number) F. SUDANO 2:24 AM QT. 03 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** BACTO MD.

If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)

ATT. 30, 2 N/A FRANKLIN WOODS 6. Sex 120 M 2 ☐ F if Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthpiece (State or Foreign Country)

D **Funerai** 214-20-0487 Yrs. Director Oct. 30, 25 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD NIA GLEN ARM, 10e. Street end Number 10g. Citizen of Whet Country? AMP CONE RD items 23a 11618 USA 21057 Funeral Pages I and 2 should be filed within 72 hours after death verif of Health and Mental Hygiene.
Int. Il them 27 is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 21215-0020 Specify: WHITE 1 Yes 2₽ No Specify: by 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Dacadant's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiamantary/Sacondary (0-12) Coilage (1-4or 5+) PRODUCE PRODUCE YENDOR 10 Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be BENJAMIN SUDANO IMPALLARIA GIACOMINA 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health at Important: If them 27 is any injury or other that once. ROBERT SUDANO (SON BALTO, 21224 Tyd. 2515 BOSTON ST. Baltimore, 20e. Method of Disposition 20b. Pleca of Disposition (Nema of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 Buriai 2 ☐ Cremation 3 ☐ Removei from State 10/6, 197 4 ☐ Donetion 5 ☐ Other (Specify) OAKLAWN CEMETERY 22. Name end Address of Fecility
Della Noce & Sons Funeral Home 21. Signature of Funerei Servine Licansee 322 S. High St. Baltimore 21202 Md. and Enter the disusse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, occ, or heart failure. List only one cause on each line. Approximata fntervel Batween Onset and Deeth **Physician** Immediete Ceuse (Finel diseese or condition rasulting in deeth) /Medicai Cerebro-Vascular Acci dent 3 yrs Examiner Examiner Due to (or es e consequence of): Sequentielly list conditions, if eny, laading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in daeth) Lest Physician/Medical Due to (or es a consequence of): To the Hospital or Attending Physicien: The law requires that the deals P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? After this certificate 1 Yes 24No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Mennar of Deeth Medical Certification: 28a. Dete of Injury (Month, Dev Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation Neturet 2 Accident within 24 hours after death.

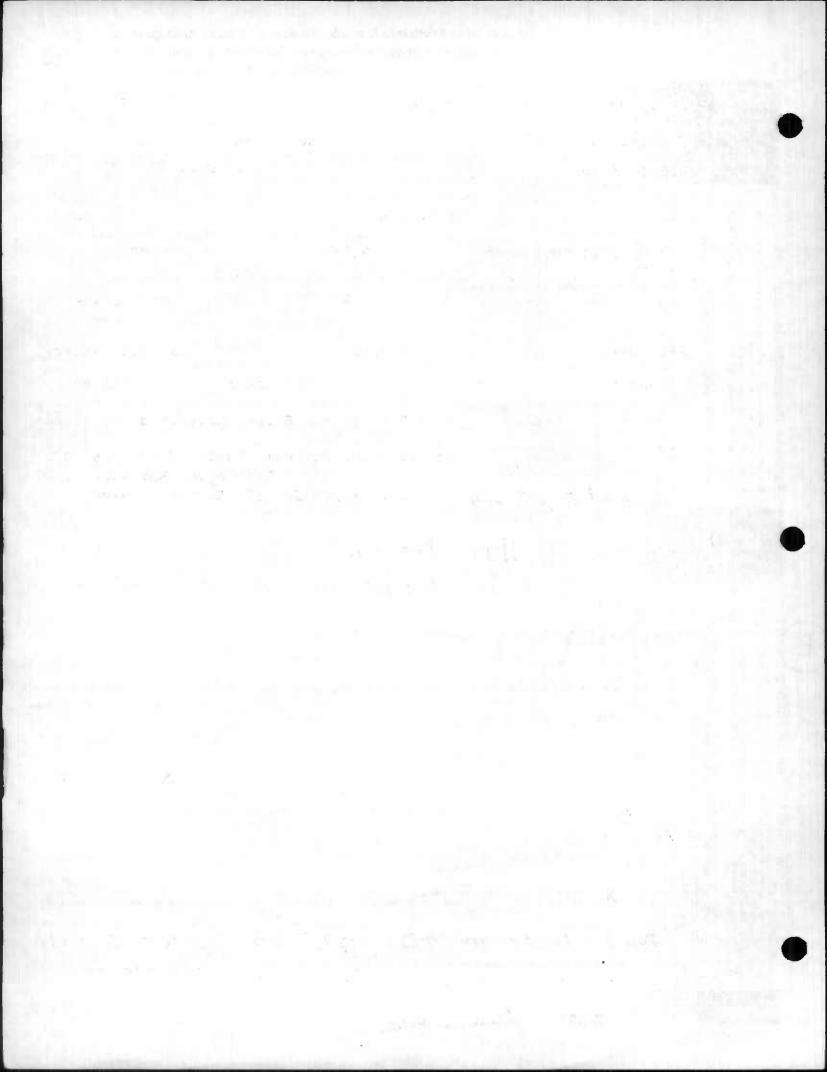
To the Funerel Director: Af
completely filled in by the fu death. 1 Yes 2 No 6 Could not be datermined 3 Suicide 28a. Placa of Injury - At home, ferm, street, fectory, offica building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the best of examination end/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and menner steted. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) cal peto 10-3-97 D050757 30. Neme end eddress of person who completed causa of daath (Item 23a) (Type, Print) ANURADHA N. RAGA PATI 9200 FRANKLIN SQUARE DR. State Registrar



# Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

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uneral irector		5. Sociei Security Number 239-12-8120 Usuel Residence of Decedent	1 M 2 F	81	i. last birthday) Yrs.	Months Deys	Hours Min.	8. Date of Birth Month, Day 11-02	-15	9. Birthpl Count NC	ece (State or Forei
show		10a. Stele 10b. County		10c. C	ity, Town or Lo	cation				10	Od. Inside City Limi
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Julia Davidson Mandall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2 Data of Death 3. Tima of Death Month Yaa **Physician** 10mpson Oa TYDOW 0 /Medical 4a. Facility Neme (If not institution give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MM Baltimore Baltimore City If Undar 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Hours 10 M 2□ F Months Deys Min. Yrs 81 278-16-7931 May 5, Director 1916 unknown Usual Rasidance of Dacedani death with the Maryland works ! 10b. County 10c. City, Town or Location 10d. Insida City Limits 77 is marked other then "natural", or items 23s or 28s-f shor traumstic event, the Medical Experient must be nutified at 1 Yas 2 No Director Maryland Baltimore City Baltimore 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 501 W. Franklin Street 21201 U.S.A. Funeral 12. Was Dacedent Ever In U,S. Armed Forcas? unknown 1 □ Yas 2 □ No If Yas, Giva 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Raca - American Indian. Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours effer.
Department of Heart and Worstal Hygiene.
Important: if Rem 27 is marked other than "natural", or item
any injury or other traumatic event. 1X Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White P 3 Widowad 4 Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) unknown unknown unknown unknown 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be unknown unknown P 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) unknown unknown 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4□Donation 5☑Othar (Specify)in state oseph B. 22. Nama and Addrass of Facility State Anatomy Board, 655 W. Baltimore Street once Van Sant Baltimore, Maryland 21201 BALTIMORE, MARYLAND 21201

23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each tine. Approximate Intarval Batween Onsat and Daath **Physician** /Medical Immediata Cause (Finel disaasa or condition rasulting in deeth) Examiner Examiner ettending physician end for use es the buriaf-transit that the death certificate be executed Sequentially list conditions, if any, leading to immadieta causa. Entar Undarlying Causa (Disaasa or Injury Dua to (or as a consequence of) P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) ed by the el deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? been signed by should be detec 4 Unknown 1 Yes 2 No 3 Probably Records, þ 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy periormed? Completed has page 2 1 Yes 2000 1 Yas 20 No certificate Division of Vital Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certifice 25. Was case refarred to medical Be 26. Pteca of Deeth (Check only one) axeminer? Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Dete of Injury (Month, Day Year) 27. Mannes of Daath 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 5 Panding invastigation 1 Naturel To the Hospital or Attandin within 24 hours efter death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be Location (Straat and Number or Rurel Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicida 1 Certifying Physician: To the best of my knowledge, death occurred et the time, deta and place, and due to the cause(s) and manner as stated. Medical 29a. Certifiar 2 Medical Examinar: On the basis of exemination and/or Invastigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and being of certifian 29c. Licansa number 29d. Date signed (Month, Pay, Yaar) 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

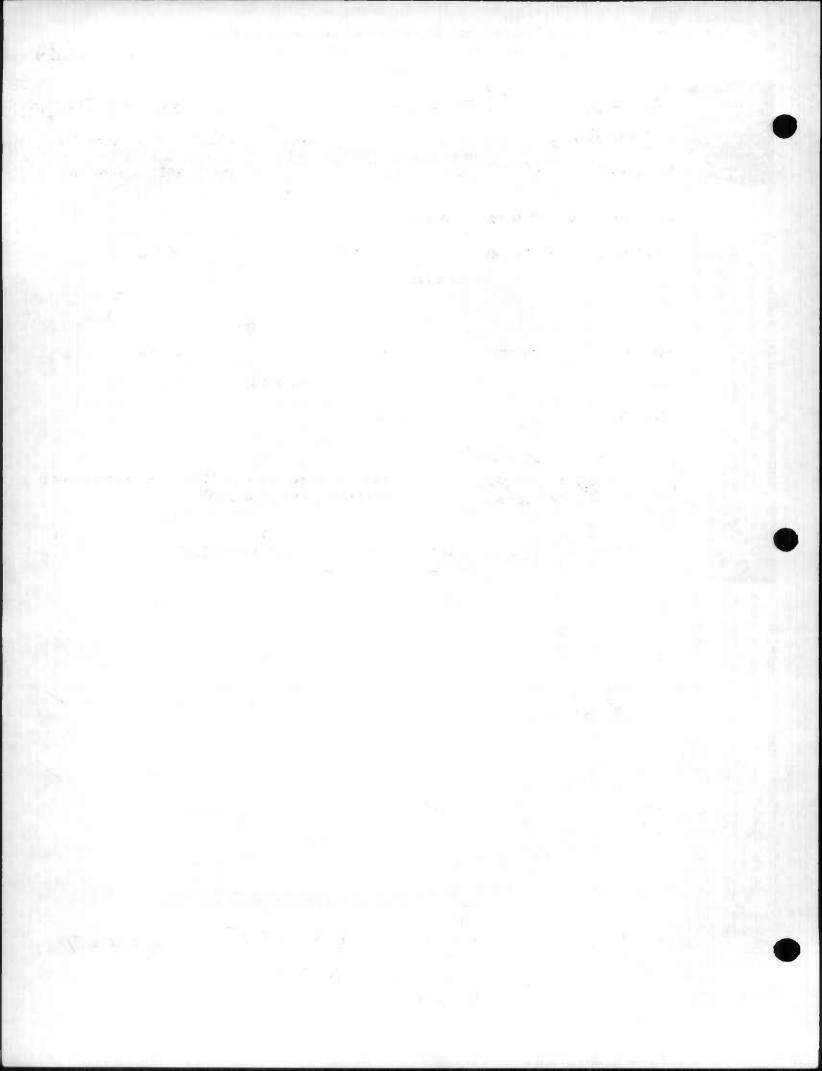
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Julie 3 DE PHILIPPE & PROHIBER

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31. Data filad (Month, Day, Year) OCT 09 1997

State Registrar



State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Malcolm Tillman Month OCF 630 am /Medical 4a. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Johns Hopkins Bayview Medical Center Baltimore Baltimore CITY 5. Social Security Number If Under 1 Yaar | if Undar 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral**  Birthpleca (Stete or Foreign Country) 1₩ M 2□ F 216-28-8576 Months Deys Hours **Director** July 22, 1935 unknown Usuel Residence of Decedent death with the Maryland 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 € No Maryland Baltimore Baltimore County 10e. Street end Number 10f. Zip Coda 10g. Citizan of Whet Country? 2000 Odell Avenue Funeral 21237 U.S.A. 12. Wes Decedant Ever in U,S. Armed Forces? 11. Maritel Statusunknown Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race · American Indian, Bieck, White, etc. filed within 72 hours after 1 Navar Merried 2 Married 1⊠Yes 2□No 21215-0020 1 Yes 2 No Specify: à Specify: Black 3 Widowed 4 Divorcad Yeer or Datas: Be Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown ages 1 and 2 should be filed very of the line of the l unknown unknown altimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumema) Stuart Tillman Lucille Madison 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zlp Code) Marion Wilkerson/sister unknown Pages 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremation 3 ☐ Removel from State Department Insportant: If any Injury or once. 4 □ Donetion 5 ☑Othar (Specify) in state R. Wade State Anatomy Board 22. Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Pert I Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one ceuse on each line. Approximeta Intervel Between Onsat and Death Physician Molignant Pericardial Effection /Medical Immediete Ceuse (Finel 10 days disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner Primary adenocarcinoma i or Attanding Physician: The law requires that the death certificate be executed efter death.

Director: After this certificate has been signed by the attending physician and Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): 1 year Lung abscess Box 68760. Physician/Medical Due to (or es e consequenca of); P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? HIV (F) 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed Alcoholism 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical axaminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Menner of Death Dete of Injury (Month, Dey Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide in 24 hou. Hospitai 24 hours e Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. Licansa number 29d. Date signed (Month, Dey, Year) Vicalea, MD Oct 2nd, 97 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
S. Chendra, 160 4940 Eastern Ave, Baltimore, mD 2/224-2780

DHMH 16 Rev 6/95

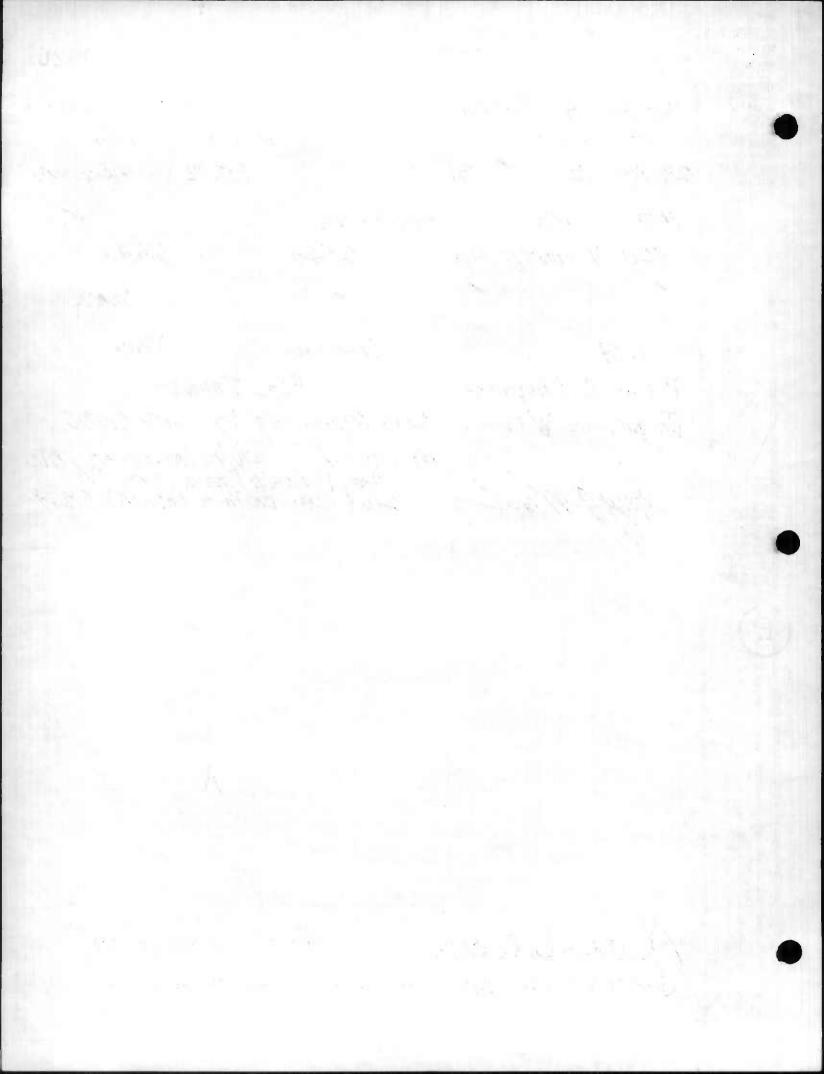
State Registrar

WRC 97-5567-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. LINDA State of Maryland / Department of Health and Mental Hygiene 30626 THOMAS Items: 23a part I,27,28a-f per MEO G-752 10/22/97 dh Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month SEPT. Day **Physician** 29, 1997 5:45 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HARBOR HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 B Yrs. -00 Director denca of Decedent 10a. State 10b. County 10d. Inside City Limits 28a-f show must be nothed at 1 Pres 2 No Director 10e. Street and Numbe the 10g. Citizen of Whet Country? b Items 23s Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. dent Ever in U.S. orces? The Medical Examiner 1 ☑ Never Married 2 ☐ Married 1 TYes Baltimore, Maryland 21215-0020 ò 1□ Yes 2□No Specify A 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than . Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) NOMIER marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme, and 2 should be (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type if Item 27 is other 20b. Place of City or Town, State 1 Dunal 2 Caremation 10 Other (Specify) 21. Signature o a, of comp cations that caused the deeth. Do not enter the mo Approximete Intervel Between Onset end Death Physician Immediate Cause (Final NARCOTIC INTOXICATION diseese or condition resulting In death) Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequenca of): Due to (or as a consequence of): Box Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by h 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by pege 2 should 24b. Were eutopsy findings available prior to 24e. Was en autopsy performed? completion of cause of deeth? hes 2 No 2 No certificate of Vital or Attanding Physician: Be 25. Was case referred to medical 26. Piece of Death (Check only one) examiner? 1X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 XER/Outpatient 3 □ DOA Certification: To 1 Inpatient this s efter death.

I Director: After this d in by the funeral d 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 Accident 9/29/97 unknown unknown Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 902 Veronica Ave., 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C completely filled Hospital Baltimore, Md. 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and menner as stated.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. SEPT. 30, 1997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

State Registrar



Physicia: /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Meralls Hygiers. Important at lens 21 is nextled other than "natural; or flams 23 a or 28e1 show any injury or other traumatic event, the Medical Examples must be notified at

Physician /Medical

> iding physician and ise as the burial-transit

Baltimore, Maryland 21215-0020

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20b. Method of Disposition  1	19a. Informe	nt's Name/Relation	nship (7	ype, Print)		- 19	9b. Mailin	g Address	(Street				ber, City	or Town,	State, Zi	p Code)	)
Commercial Cause (Final disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory errest, if any, leading to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contribute to the cause in the pert I.    Pert II. Other significant conditions contribute to the cause in the pert I.    Pert II. Other significant conditions contribute to the cause in the pert I.    Pert II. Other significant conditions contribute to the cause in the pert I.    Pert II. Other significant conditions contribute to the cause in the pert I.    Pert II. Other significant conditions contribute to the cause in the pert I.    Pert II. Other significant conditions contribute to the cause in the pert I.    Pert II. Other significant conditi	unkn	own					unk	nown									
22. Nama and Address of Fecility State Anatomy Board, 655 W. Baltimore Str. Baltimore, Maryland 21201  23a. Parf. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, interval and conditions of the conditions of the cause of the cause of the conditions of the cause	1 🗆 Buria	al 2 Cramation				20b. Pleca cemai	of Disportery, crem	sition (Nar natory or o	ne of other place	се)	1	Date	20c.	Location -	City or T	own, St	ete
Due to (or es e consequence of):    Sequentielly list conditions, if env, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Lest    Due to (or es e consequence of):	An			Una C	1.												
Due to (or es e consequence of):  d	23a Parri. E shock, o	Enter the disaasa, or heart feilure. Lis	or comp	olications thet	causad	the death. Done.	В	altin	nore	, Mar	ylan	d 2120	1	Balt	imor	Appro	
Due to (or es e consequence of):  d	Immediate Codisease or co	or heart feilure. List	or comp sf only o	olications thet one ceuse on	causad eech lir	10.	B not ente	altin er the mod	nore le of dylr	, Mar	ylan cardiec	d 2120	1	Balt	imore	Appro	eximete val Between
Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the cause of the confidence of the confidence of the cause of the completion of deeth?  24e. Wes en eutopsy performed?  24b. Were eutopsy evaliable price completion of deeth?  197es 2 No 197es 2 No 197es 2  25. Wes case referred to medical exeminer?  10 Yes 2 No 197es 2  26. Place of Deeth (Check only one)  27. Menner of Deeth   Nursing Home   Septiment   Immediate C disease or co resulting in di	ause (Final ause (Final andition eath)	or comp sf only o	olications thet one ceuse on	causad eech lin	btoT  Due to (or es	B o not ente	altin	nore le of dylr	, Mar	ylan cardiec	d 2120	1	Balt	imore	Appro	eximete val Between	
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24e. Wes en eutopsy performed?  24b. Were eutopsy performed?  24b. Were eutopsy performed?  25c. Wes case referred to medical exeminer?  1	shock, of the shock of the shoc	list conditions, g to immediate underlying see or Injury events	or comp sf only o	olications thet one ceuse on	causad each lir	Due to (or es o	B o not ente	alting the module of the modul	nore le of dylr	, Mar	ylan cardiec	d 2120	1	Balt	imore	Appro	eximete val Between
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exeminer?  1 X Yes 2 No  Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigetion 2 Accident Residence 6 Octobro Residence 6 Other (Specify)  WC  1 Yes 2 No  1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)  WC  1 Input of Injury of Work?  TOWN LUCY  T	shock, of Immediate C disease or consulting in disease or consulting in disease. Enter Ceuse, (Disease that initiated rasulting in disease)	ist conditions, g to immediate Underlying see or Injury earth) Lest	or comps only c	bd.	causad eech lir	Due to (or es o	B o not enter	alting the mode of	nore le of dylr	, Mar ng, such es	ylan cardiec	d 2120 or respiretory	1 errest, d tobacc	co use co 2 Mo	ntribute 1 3 Pro	Approximation of the control of the	ause of death  Unknow
27. Menner of Deeth  1 Neturel  28e. Dete of Injury  (Month, Day Year)  28b. Time of Injury  (Month, Day Year)  28b. Time of Injury  (Month, Day Year)	shock, of Immediate C disease or consulting in disease or consulting in disease. Enter Ceuse, (Disease that initiated rasulting in disease)	ist conditions, g to immediate Underlying see or Injury earth) Lest	or comps only c	bd.	causad eech lir	Due to (or es o	B o not enter	alting the mode of	nore le of dylr	, Mar ng, such es	ylan cardiec	d 2120 or respiretory 23b. Di	1 errest, d tobacc	co use co 2 1 No lopsy	ntribute t 3 □ Pro	Approximation of the control of the	ause of death  Unknow
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4 Homicide determined determined determined determined building, etc. (Specify)	Sequentially if any, leading cause. Enter Ceuse (Disecthat initiated rasulting in december 1). Other	list conditions, g to immediate Underlying see or Injury each Lest  segnificant conditions (a preferred to medic)  2 No  Deeth	Stone co	b	causadeech lir	Due to (or es e	Bonot enter consequences conseq	alting the mode of	ause giv	yen in Pert i	ylan cardiec	d 2120 or respiretory  23b. DI  1[ 24e. Wr pe  1§ h (Check only) me 5 □ Re 28d. Describ	1 errest, d tobacc Yes ' es en eut formed?  Yes one) sidence e how in	co use co 2 No lopsy 2 No 6 Noth	ntribute t 3 Pro 24b. We en colored	Approcintary Conse	ause of death  4 Unknown opsy findings prior to on of causa
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end menner as stated.	shock, of Immediate Codes are corresulting in disease or corresulting in disease or corresulting in disease. Enter Ceuse (Disease that initiated rasulting in disease) and the codes of the code of th	ilist conditions, g to immediate Underlying see or Injury events seath) Lest  significant conditions or referred to medic lest less than the lest less than the lest less than the lest less than the lest less than the lest less than the lest less than the lest less than the lest less than the lest less than the lest less than the lest less than the lest less than the lest less than the lest less than the l	Colone cooperating tigetion d not be	b  b  d  Hospitel: 1  28e. Dete	causadeech lir	Due to (or es e	B o not enter e consequence consequence o consequence consequence in the unit of the consequence conse	alting the mode of	DA Oth	yen in Pert i	ylan cardiec	d 2120 or respiretory  23b. Di  1[  24e. Wi pe  1§ h (Check only me 5 □ Re 28d. Describ  28f. Location City or 7	d tobacc  Yes  seen eutiformed?  Wes  one)  sidence e how in  (Street town, Sta	co use co 2 PNo lopsy 2 No 6 Øbth jury occur S and Numbite)	antribute 1 3 Processor of Special Spe	Approximation of the cut of the c	ause of death  4 Unknow opsy findings prior to on of causa  2 No IN WOODS

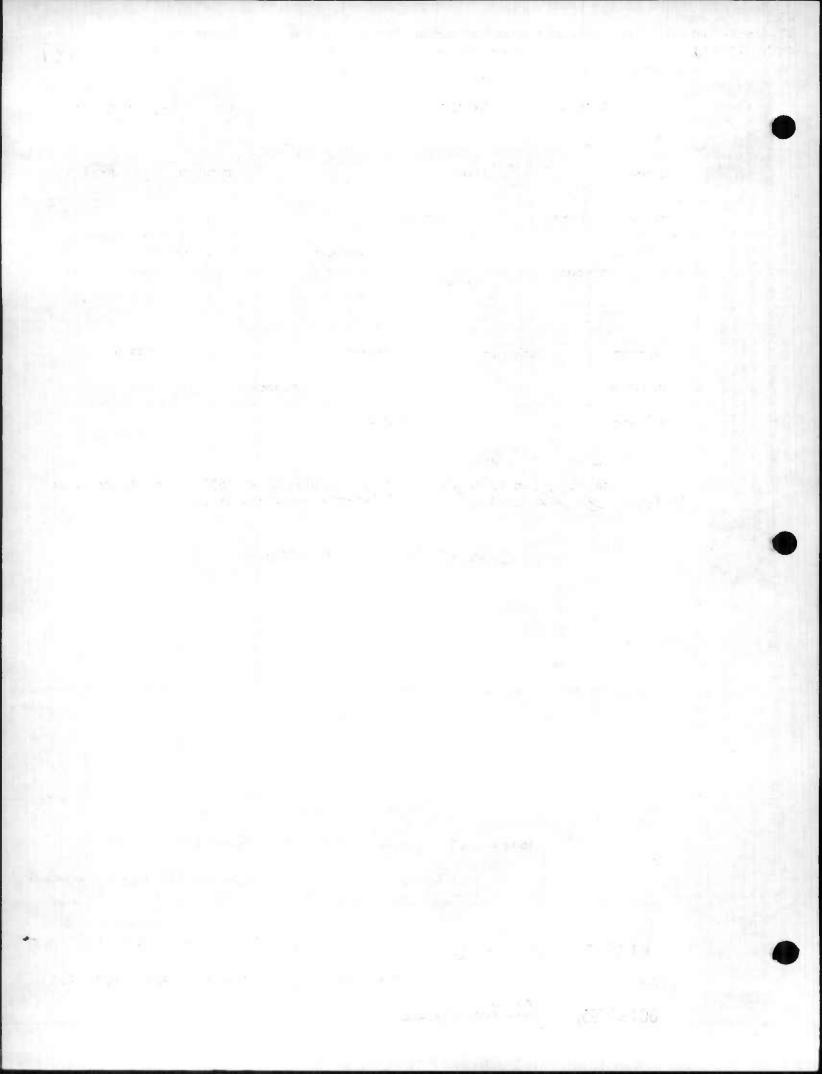
To the Hospital or Attending Physician: The law requiries within 24 hours after death.

To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be

Division of Vital Records, P.O. Box 68760,

State Registrar 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

A Combination of the C



**Physiclan** /Medical Examiner

**Funeral** Director

Page 7 end 2 should be filed within 72 hours after death with the Maryland man of Health and Mental Hygiene. Capariment of Health and Mental Hygiene.
Important if hem 27 is marked other than "natural", or items 23s or 28s-f show any futury or other traumatic event, the Medical Examiner must be notined at 900.8.

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

1. Decedent's Neme (Frist, Middle, Last)   UNKNOWN 97-141   2. Detent Death   Decedent's Neme (Frist, Middle, Last)   UNKNOWN 97-141   2. Detent Death   Decedent's Neme (Frist, Middle, Last)   UNKNOWN 97-141   2. Detent Death   Decedent's Neme (Frist, Middle, Last)   UNKNOWN 97-141   2. Decedent's Neme (Frist, Middle, Last)   UNKNOWN 97-141   2. Decedent's Neme (Frist, Middle, Last)   UNKNOWN 97-141   2. Decedent's Neme (Frist, Middle, Last)   UNKNOWN 97-141   2. Design of Neme (Frist, Middle, Last)   UNKNOWN 97-141   2. Design of Neme (Frist, Middle, Last)   UNKNOWN 97-141   2. Design of Neme (Frist, Middle, Last)   UNKNOWN 97-141   2. Design of Neme (Frist, Middle, Last)   UNKNOWN 97-141   3. Decedent's UNKNOWN 97-141   3. Deceden		Pleas	se Type or State o		nd / E	epar	tmen	t of I	Health	and N	II Copies Jental Hy		- Free	30628
UNKNOWN 97-141  4e. Festility Name (If not institution, give street and number)  2020 S. CLINTON ST. (PIER 1)  S. Social Sacutify Number  10 Nover Number  10 Nover Number  10 Nover Number  10 Nover Number  10 Nover Married 2D Married  10 Nover Marr						Ceru	iical	e oi	Deali					
UNKNOWN 97-141  2020 S. CLINTON ST. (PIER 1)  5. Social Security Number   6. Sex   Town or Location   Town o	117 7 117												/ Yeer	
S. Social Security Number   G. Sex   Unknown   G. Sex	UNKN	OWN 97	L41										1997	
5. Social Security Number Unknown  10 M 2 F 10 M 2 M M 10 M 10	The state of the state of	. THE SHALL SAN			1 1							th 4c.	County of De	eth
Unknown    15M 2   F   unknown   Vrs.   Months   Deys   Hours   Min.   (Month, Dey, Year)   Unknown   Unkn						hday)	If Under	1 Year				idh	0.8	irtholoca (State or Foreig
10c. Stele   Unknown   U	Unknown						Months	Deys						Country)
Unknown  10e. Street and Number Unknown  11. Marifel Status Unknown  11. Marifel Status Unknown  11. Marifel Status Unknown  11. Marifel Status Unknown  11. Marifel Status Unknown  11. Marifel Status Unknown  11. Marifel Status Unknown  12. Wes Decedent Eyr in U.S. Armed Forces? Unknown  13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Count, Maxican, Puerio Rican, etc.)  14. Race - Americen Indien, Black, White, etc.  15. Decedent's Education  (Specify only highest grade completed)  [Give kind of Business/Industry  (Rive kind of B			-	10c (	City Town	or Loca	tion	-						10d Incide City Limite
Unknown  11. Maritei Status Ünknown  12. Wes Decedent Eyer in U.S. Armed Forces? Unknown  13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, Specify Section Mexican, Puerto Rican, etc.)  13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, Specify Section Mexican, Puerto Rican, etc.)  14. Rece - American Indian, Bleck, White, etc.  15. Decedent's Education (Specify or No Injenset grade completed)  (Specify or No Injenset grade completed)  (Specify or No Injenset grade completed)  (Specify or No Injenset grade completed)  (Inknown  15. Decedent's Education (Specify or No Injenset grade completed)  (Specify or No Injenset grade completed)  (Inknown  16. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)  17. Fether's Neme (First, Middle, Last)  18. Mothar's Name (First, Middle, Meiden Surneme)  19. Informent's Name/Reletionship (Type, Print)  19. Informent's Name/Reletionship (Type, Print)  19. Mailing Address (Street end Number or Flural Route Number, City or Town, State, Zip Code)  10. Unknown  19. Informent's Name/Reletionship (Type, Print)  19. Mailing Address (Street end Number or Flural Route Number, City or Town, State, Zip Code)  10. Unknown  10. Date of Disposition (Name of Cemelory, cremetory or other place)  20. Location - City or Town, Stata  21. Signature of Pineral Service Location  22. Name and Address of Facility  23. Name and Address of Facility  24. Same and Address of Facility  25. Sate Anatomy Board, 655 W. Baltimore Street  26. Baltimore, Maryland 21201  26. Drowning  Dua to (or as a consequence of):  27. Sequentially list conditions, if eny, leading to Immediate Cause (Fine)  28. Print Lent the disease, or complications that caused the deeth.  29. Dua to (or as a consequence of):  29. Dua to (or as a consequence of):  29. Dua to (or as a consequence of):  29. Print Lent the disease, or completed or the place of Disposition (Printer)  29. Dua to (or as a consequence of):  29. Dua to (or as a consequence of):	1 - 1 (3)		own				anori .							unknown
11. Maritel Status Unknown 11. Maritel Status Unknown 11. Maritel Status Unknown 11. Maritel Status Unknown 12. Wes Decedent Eyer in U.S. Armed Forces? Unknown 13. Widowed 4 □ Divorced  14. Rece - American Indian, Black, White, alc. 11. Yes. 2[0] No. Specify:  15. Decedent's Education (Specify only highest prede completed)  Elemantary/Secondary (Pt.2)  Collega (1-4or 5+)  Unknown  17. Fether's Name (First, Middle, Last)  Unknown  19e. Informent's Name/Reletionship (Type, Print)  Unknown  19e. Informent's Name/Reletionship (Type, Print)  Unknown  20e. Method of Disposition 1 □ Buriel 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 [Qither (Specify) in State 21. Signature of Purear Service Unchanges  Wade, Director  22. Name and Address of Fecility State Anatomy Board, 655 W. Baltrimore Street  Baltrimore, Maryland 21201  23e. Pirst. Enter the disease, or complications that caused the-deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, inches Baltrimore cause on each line.  Diva to (or as a consequence of):  Dua to interest print in the disease or conditions, if it envy, leading to immediate cause. Entar Underlying the limited everts.  Dua to interest print in the disease or conditions, if it envy, leading to immediate cause. Entar Underlying the limited everts.  Dua to (or as a consequence of):	10e. Street end No	umber					10f. Zip	Code				10g. Citi	zen of Whet C	Country?
1   Never Married 2   Married   1   Yes, 2   No   Yes, 1	Unknown						Unk	now	n			Un	known	
15a. Decedent's Educetion   15a. Decedent's Usuel Occupation   15a. December   15a.	1 Never Man	ried 2 Marrie	ed 1 ☐ Yes If Yes, Gi	2 □ No ve	u,s. .nown						ecify Yes or N Rican, etc.)	0-	Bleck, Wh	ite, etc.
Unknown  17. Fether's Name (First, Middle, Last) Unknown  18. Mothar's Name (First, Middle, Meiden Surneme) Unknown  19e. Informent's Name/Reletionship (Type, Print) Unknown  19e. Informent's Name/Reletionship (Type, Print) Unknown  20e. Method of Disposition 1		15. Decedent	s Educetion	4103.	16a.	Deceder	nt's Usue	ol Occup	oation during mos	st of work	dha	16b. KI	nd of Busines	s/industry
17. Fether's Neme (First, Middle, Last) Unknown  19e. Informent's Name/Reletionship (Type, Print) Unknown  20e. Method of Disposition   Buriel   2   Cremetion   3   Removel from State   4   Donation   5   QOther (Specify)   in state  21. Signature of Disposition   State   Street end Number or Rural Route Number, City or Town, State   20c. Location - City or Town, State	Elemantary/Sec	ondary (0-12)	Collega (						d)	3. 0. 17017	9	known		
Unknown  20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) in state  21. Signature of Puneral Service Lognage 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street  Baltimore, Maryland 21201  23. Plant. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, interval Between Onset and Deeth  Immediate Ceuse (Final disease or condition resulting in deeth)  Dua to (or as a consequence of):  Dua to (or as a consequence of):  Dua to (or as a consequence of):	17. Fether's Neme	(First, Middle, L										e, Meiden	Sumeme)	
20e. Method of Disposition    Date   Date   Date   Date   Date			Ip (Type, Print)					(Street	end Numb	er or Rui	ral Route Numi	ber, City o	r Town, Stete,	Zip Code)
1   Buriel 2   Cremetion 3   Removel from State 4   Donation 5   Other (Specify) in state     21. Signature of Funeral Service Decrease   Wade, Director   State Anatomy Board, 655   W. Baltimore Street   Baltimore, Maryland 21201     22. Name and Address of Fecility   State Anatomy Board, 655   W. Baltimore Street   Baltimore, Maryland 21201     23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast,   Approximata Interval Between Onset and Deeth   Interval Between Onset and Deeth   Dua to (or as a consequence of):    Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Ceuse (Disease or Injury thet initiated events   Dua to (or as a consequence of):    Dua to (or as a consequence of):   Dua to				Factor										
21. Signature of Funeral Service Locates Roald Swade, Director Roald Swade, Director Roald Swade, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201  23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, Interval Between Onset and Deeth  Immediate Ceuse (Finel disease or condition resulting in deeth)  Drowning  Dua to (or as a consequence of):	1 ☐ Buriel 2	Cremetion		State	cemeter	Dispositi y, creme	ion (Nen tory or o	ne of ther ple	ce)	1	Date	20c. Lo	cation - City o	r Town, Stata
Immediate Ceuse (Finel disease or condition resulting in deeth)  Sequentially list conditions, if eny, leading to immediate cause. Entar Undarrying Ceuse (Disease or Injury thet initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	21. Signature of F		ald S Wa	de,Dir	ecto								altimo	re Street
disease or condition resulting in deeth)  e. Drowning  Dua to (or as a consequence of):  b. Dua to (or as a consequence of):  if eny, leeding to Immediate cause. Entar Undarlying Ceusa (Disease or Injury that initiated events  Dua to (or as a consequence of):	23a. Part1. Enter	the diseese, or o ert feilura. List o	complications that only one couse on e	caused the de sech line.	eth. Do n	ot enter	the mod	e of dyl	ng, such es	cardiac	or respiretory	errast,		Interval Between
Sequentially list conditions, if eny, leading to Immediate cause. Entar Undarrying Ceusa (Disease or Injury thet initiated events	disease or conditi	on	e Drow	ning										
if eny, leeding to Immediate cause. Entar Undarlying Ceusa (Disease or Injury thet initiated events  Due to (or as a consequence of):				Dua to	(or as a c	onsequa	ince of):							
thet initiated events	cause. Entar Und	ariving	b	Dua to	(or as a c	onseque	nce of):							
	thet initieted event	s	c	Due to	(or es a c	onseque	nce of):			Ш				

**Physiclan** /Medical **Examiner** 

The law requires that the death certificete be executed

Examiner sate has been signed by the attending physician and pege 2 should be detached for use as the buriel-tren Physician/Medical þ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p Be Medicai Certification: To

27.

25. Wes cesa raferred to medice!

31. Dete filed (Martin 1979)

4 - Homicida

After this certificate has

Division of Vital Records, P.O. Box 68760,

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Were autopsy findings aveilable prior to completion of cause of deeth?

XX Yas 26. Piece of Deeth (Check only one)

2 No

XXYes 2 No

exeminar? 1 ☑XYes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA Other: 4□ N	Nursing Home	5 ☐ Residence	8 Othar (Specify)	SCENE
Mannar of Death	28a. Date of Injury	28b. Tima of	28c. Injury et	28d.	Describe how Inj	ury occurred	

5 Pending Investigation (Month, Day Year) 1 Natural Found 7-4-97/7:15 P M 2 Accident Could not be determined 3 Suicide 28a. Place of Injury - At home, ferm, straat, fectory, office building, etc. (Specify)

Injury Work? 1 Yes Unknown

Found: in water/near pier 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 2020 S. Clinton St., Baltimore City, MD

1 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

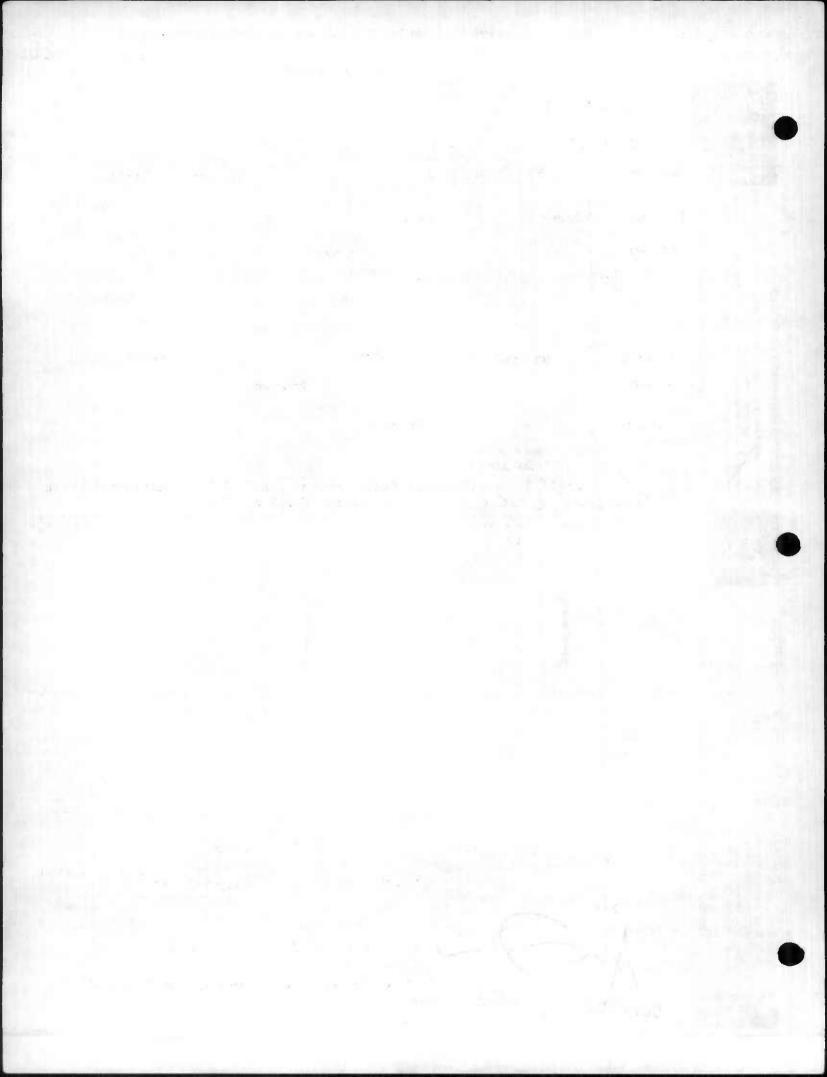
\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signeture end titla of certific 29c. License number 29d. Data signed (Month, Day, Year)

30. Name and cause of death (Item 23a) (Type, Print) July 5, 1997

State Registrar

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.



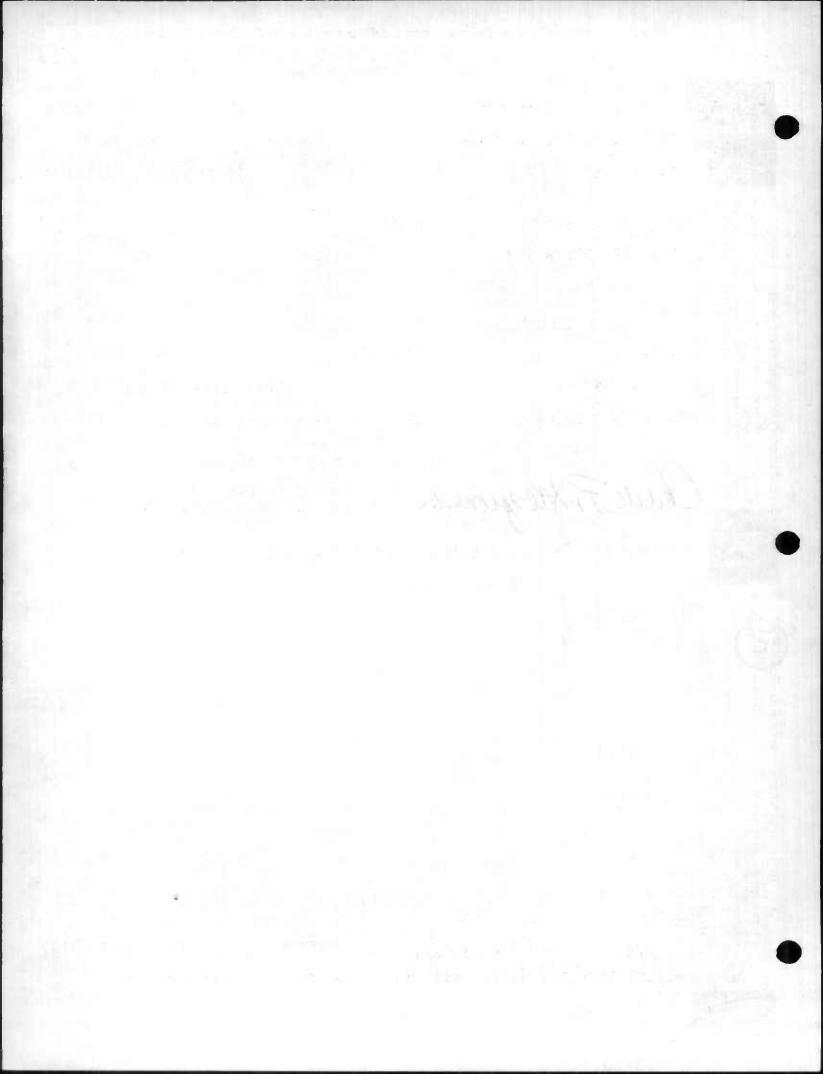
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 30629

eted by Funeral Director	5. 2 Us 10 M	SAINT JOSEPH Social Security Number 6.	S HOSPI	TAL			4b. City, Town, or I	OCTOBE			0920am
by Funeral Director	5. 2 Us 10 M	SAINT JOSEPH 6.  Social Security Number 6.  14-26-5269  sual Residence of Decedent De. Stete 10b. County  ARYLAND BAL	S HOSPI	TAL 7. Age (In yrs.				1	-		
by Funeral Director	5. 2 Us 10 M	Social Security Number  14-26-5269  sual Residence of Decedent De. Stete 10b. County  ARYLAND BAL	Sex	7. Age (In yrs.					To. County	or Death	
by Funeral Director	2 10 M	14-26-5269 sual Residence of Decedent De. Stete 10b. County  ARYLAND BAL					TOWSON		ВА	LTIMO	RE
by Funer	10 M	ARYLAND BAL			7 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da 11-27	rth ay, Year) -29	9. Birthplac Country) MAR	e (State or Foreign YLAND
by Funer	10			10c. Ci	ity, Town or Loca	ation				10d.	Inside City Limits
by Funer	L	De. Street and Number	TO.		BALTO						1 ☐ Yes 2 ☐ No
by Funer	$\vdash$					10f. Zip Code			10g. Citizen of	What Country	7
by Funer	11	5845 DAY BREA	K TERR.			21	206		U	SA	
		Marital Status     Never Married 2 Married     Widowed 4 □ Divorced	12. Was Dece Armed For 1  Yes If Yes, Giv Year or Da	ces? 2\( \) No		as Decedent of Yes, specify Cut	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No Rican, etc.)	5- 14. Rac Bla Specif	ce - American ck, White, etc.	
Pe	-	15. Decedent's E	ducetion		16a. Deceder	nt's Usuel Occu	pation		16b. Kind of B		
Completed		(Specify only highest gi	ede completed) College (1	-4or 5+)	HOMEM		pation a during most of wor ad)	king	OWN	HOME	
9	17	7. Father's Name (First, Middle, Las	"				18. Mother's Nan	ne (First, Middle	, Maiden Sumen	ne)	
10	1	LEON ADAMSKI							ANDOWS		
		9a. Informant's Name/Relationship R. ARTHUR UMBI					t and Number or Ru				
	1		INGER		5845		REAK TE				
	20	Da. Mathod of Disposition 1 □ Burlal 2 □ Cremetion 3 [	Removal from S		Pleca of Disposit cametery, crema	tory or other pla	ace)	Date	20c. Location	City or Town,	Stete
	12	Donation 5 Other (Special	fy)	HO	LY ROS	ARY CE	METERY	10-8-9	7 BALTI	o. co.	MD.
a .	/2	1. Signature of Euneral Service Lice	nsee		22.1	Name and Addr	ess of Facility				
Important any injury otice		MANITON	Almi	mela	KA	CZOROW	SKI FUN	ERAL H	OME		
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	1	shock, or heart failure. List only	one cause on ea	ich line.	(ii. Do not enter	the mode of dy	ing, such as cardiac	or respiratory a	irrest,	Int	erval Between aset and Death
n ol	le:	amadiata Causa /Final									iset and Death
9F	l di	nmediate Cause (Final isease or condition esulting in death)	a. END	STAG	E OF H	EART F	AILURE				
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Examiner			b RE.N	AL FA	ILURE						
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Physician/Medical			d							ĺ	
an											
sic	Pa	art II. Other aignificant conditiona	contributing to de	ath but not res	sulting In the und	erlying cause gi	iven In Part I.	23b. Did	tobacco uae co	ntributa to th	e causa of death?
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by										T	
Completed								24e. Wes	an autopsy ormed?	aveila	eutopsy findings ble prior to
0.	-						· · · · · · · · · · · · · · · · · · ·			of dea	etion of cause th?
0								10	Yes 2 No	1 □ Y	es 2 No
Be	25	. Was case referred to medical					26. Place of Dea	th (Check only	one)		
To Be Com		exeminer? 1 Yes 2 XNo	Hospital:	patient 2	ER/Outpatient	3 DOA Ot	hor		Idence 6 Oth	ner (Specify)	
	27	. Manner of Death	28e. Dete o		28b. Time of	28c. Inju			how injury occur		
ation:		1 Naturel 5 Pending 2 Accident investigation		, Day Year)	injury		ork? ]Yes 2 ☐ No				
Certification:		3 Suicide 6 Could not t	e 28e. Placa	of Injury - At h	ome, farm, stree	t, factory, office		28f. Location (	Street and Numi	ber or Rural Re	oute Number,
ent		4 Homicide	buildin	g, etc. (Specia	ry)			City or To	wn, State)		
Medical C	29	Pa. Certifier  (Check only one)  1 XCartifying Pl 2 Medical Example 1	nyelcian: To the to ninar: On the ba and mann	sis of examina	owledge, death o ation and/or inves	ccurred at the ti stigation, in my	ime, date and plece opinion, death occu	, and due to the rred at the time,	cause(s) end madate and place,	anner as state and due to the	d. e cause(s)
Medicai Certifi	29	b. Signature and title of certifier	0	/		29c. Licen	se number		29d. Date signe	d (Month, Day	(, Year)
		10.	SXI			Н	43974		ОСТОЕ	ER /	1997
	20	Nome and address of	nompleted	Party III	22		7// 4		0010	BER 4,	177/
	F	Name and address of person who ALILCE SHYA-SH	I HSTF	H 76'	20e) (Type, Pr	( ROAD	TOWSON,	MARVI	AND 21	204	
State	-	. Date filed (Month, Day, Year)		gistrar's Signa				HIMINI L	LAND Z	204	

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DHMH 16 Rav 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WILHEIM 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5. Social Security Number 6.5 benatrics Certe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 200 Days 3 217-22-9286 9 Yrs. Oct. 29,190 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 □ No altimore N/A 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? Bay view 2122 5505 Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian Biack, White, etc. 11. Meritel Status 1 Never Married 2 Married 1□Yes 2□No White Specify Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME HOUSEWIFE 12 yrs. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) CARRIE WATSON WILLIAM KEYSEER 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) RT. 1, BOX 54 HUDDLESTON, VA 24104 THOMAS WILHELM/SON 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Deurial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE CEMETERY10/7/97 BALTIMORE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility DABROWSKI MATTHEWS BRADLEY ASHTON rock 2134 WILLOW SPRING RD. MD. 21222 DUNDALK, 23a. Part1. Enter the disease, or complications that caused shock, or heart fallure. Lest only one cause on each lips n. Do not enter the mode of dying, such es cardiec or respiretory arrest, Approximate Interval Between Onset and Deeth ASCVA Immediate Cause (Final disease or condition resulting in death) 104KS Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evellable prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 1 🗆 Yes 2/2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

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Physician/Medical Examiner þ Completed Be 10

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Baltimore, Maryland 21215-0020

Certification:

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neral Director: After this of filled in by the funeral di To the Hospital o within 24 hours of To the Funeral D completely filled i

Medical

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State Registrar

Certifying Phyaiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. 29a. Cartifier 29b. Signature and title of certified

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 Netural 2 Accident

3 Sulcide

4 Homicide

MN

28a. Date of Injury (Month, Day Year)

29c. License number

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAON

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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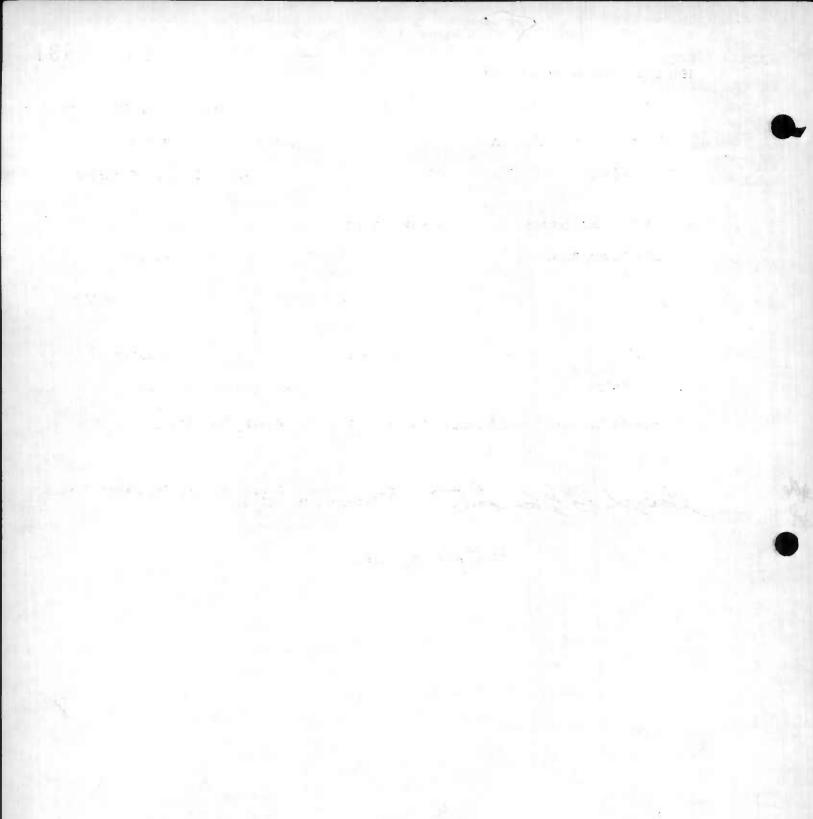
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State of Maryland / Department of Health and Mental Hygiene 97 30631

	_	EM: 26,29a per DR. 1. Decedent's Name (First, Midd	lle, Last)					2. Date of D			3. Time of Death
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mine	r	4a. Facility Name (If not institution						or Location of Dea	ath 4c. County	y of Death	
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ral tor		5. Social Security Number  219-48-6831  Usual Residence of Decedent	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs.	1 Yrs.	if Under 1 Year Months Days	If Under 24 H Hours Mi	in. (Month, L	0 , 1936	9. Birthplac Country Scotla	ce (State or Foreign and
	- 1	10a. State 10b. County	/	10c. Cit	y. Town or Loc	cation				10d	I. Inside City Limits
	× -		gomery		llver S	pring					1 ☐ Yes 2€ No
		10e. Street and Number				10f. Zip Code			10g. Citizan of		n
	a l	10503 Royal Ro			2 40 14	209			U.S.		
	by Funeral	11. Marital Status  1 □ Never Married 2 □ Mar  3 ☑ Widowed 4 □ Divorced	ried Armed F	2 ₹ No Sive		Vas Decedent of I Yes, specify Cub ☐ Yes 2 ☑ No		(Specify Yes or Nerto Rican, etc.)	Io- 14. Had Bia Specif	ce - American ck, White, etc fy: whi	o.
	Completed	15. Deceder (Specify only highe	nt's Education est grede completed	)	16a. Deced	ent's Usuai Occup kind of work dona DO NOT use ratire	oation during most of w	rorking	16b. Kind of B	Businass/Indu	stry
	E	Elamantary/Secondary (0-12)	College	(1-4or 5+)			ω)		T) 1	4.1	
		17. Father's Name (First, Middle,			Te	acher	18 Mother's N	ame (First Midd	Educa le, Maiden Surnar		
	ă	Thomas Smith	2001/								
F	0		hi- (T		10. 1		-		lexander		
		19a. Informant's Name/Relations		1 1 .					ber, City or Town.	, Stete, Zip C	ode)
	-	Elizabeth M. Wo	oodstock/				88A, Ch		24072	0: =	
		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4X□ Donation 5 □ Other (S			emetery, crem	sition (Neme of setory or other ple	ce)	Date	20c. Location	- City or Towr	n, State
9000		21. Signature of Funarai Service	Licensee eph B V	an Sant	S	Name and Addre tate Ana altimore	tomy Boa	ard, 655 1201	W. Balt	imore	Street
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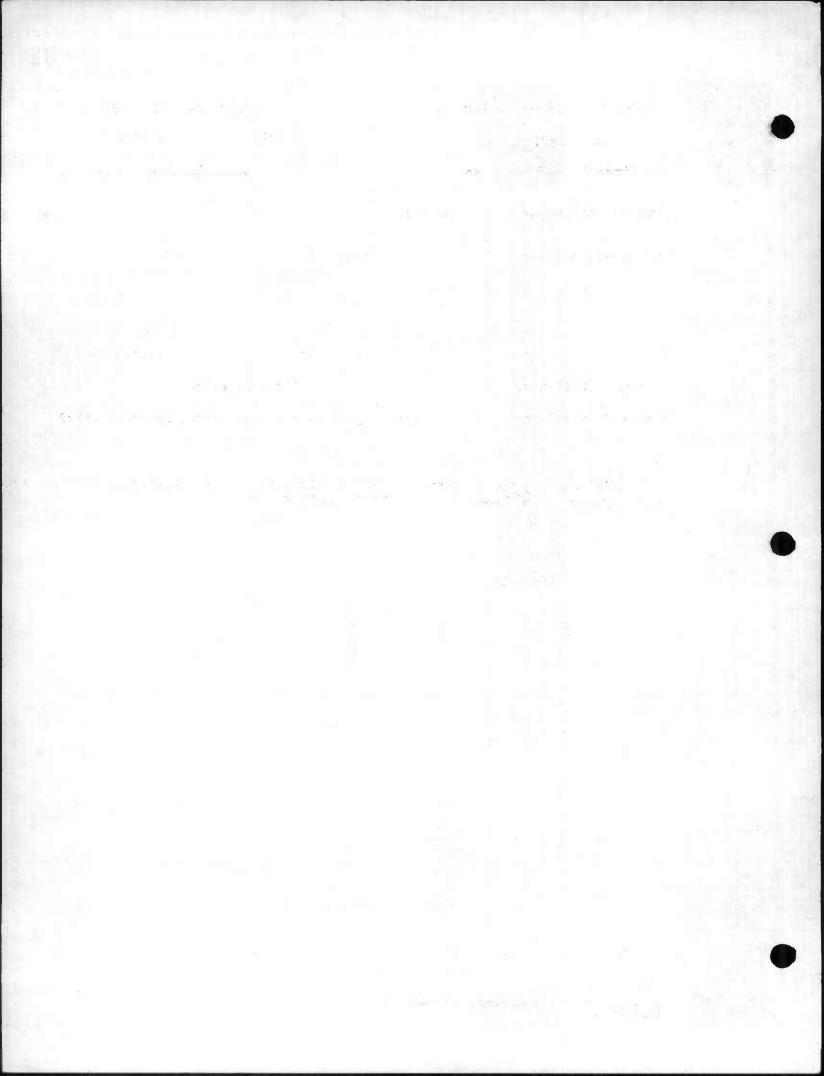
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State of Maryland / Department of Health and Mental Hygiene 97

97 30632

	Item:8	per	Informant G-752 10/14	/97 dh	(	Certifica	te of	Death		R	g. No.	1	00002
	Dhusia		1. Decedent's Nama (First, Middla, Li	as()						Data of Deat	h Day	Yaar	3. Time of Death
	Physic /Medi		Albert Jose	eph Willinge	r						er 22,		12:05 am
	Exami		4a. Facility Nama (If not institution, gir						wn, or Locatio	n of Death	4c. County		
			Anne Arundel Me			-		Dund			Balti		
	Funeral Director		215-34-8983	Sax 7. Aga (In yrs 1		nday) If Und Months	er 1 Year Days	Hours	Min. 8. C	Pata of Birth Wonth, Day,	12/19/36 <i>Year)</i> 1936		placa (Stata or Foraign htty) ryland
	pu .		Usual Rasidance of Decedant  10a. Stata 10b. County	100 0	ity Town	or Location	_					1	Od Incide Ohy Limite
	Be-f sho	Director	Maryland Baltim		indal								1 ☐ Yas 24 No
	23a or 24		10e. Street and Number 1889 August Aver	nue			ip Coda 222				0g. Citizan of V	Vhat Coun	itry?
21215-0020	d 2 should be filed within 72 hours efter deeth with the Meryland th and Mental Hygiens. 7 is marked other than "natural", or frems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedant Evar in I Armed Forcas? 1 ☐ Yas 2戶 No If Yas, Giva Yaar or Datas:	J,S.	13. Was Dec If Yas, sp 1 ☐ Yas		lispanic Orig an, Maxican Specify:	gin? (Specify i, Puarto Rica	Yas or No- n, atc.)	Biac	e - Amaric k, Whita, Whi	
5-0	72 ho	Completed	15. Decedant's E (Specify only highast gr	ducation	16a. [	Decedant's Us	ual Occup	ation	Lof working		16b. Kind of Bu	isinass/Ind	dustry
21	within ene.	nple	Elamentary/Secondary (0-12)	Collega (1-4or 5+)	1	Giva kind of w lifa. DO NOT			or working	1			
	filed with Hygiene. ther then	Cor	9	0		Superi	nten				Consti		on
and	Hall H	Be	17. Fathar's Nama (First, Middla, Last Joseph T. Willi						rs Nama <i>(Fir</i> een W.		Maidan Sumam	a)	
Z Z	2 should be filed v and Mental Hygie is marked other t sumstic event, th	10	*		400		(0)						
, Maryland			19a. Informant's Name/Ralationship Dolores K. Willi	nger - wife	18	889 Aug	ust				, City or Town, , Mary]		
Baltimore,	permit. Pages-1-tife Department of Heel Important: if item 2 any injury or other ance.		20a, Mathod of Disposition  1 Buriai 2 Cramation 3 4 Donation 5 Other (Speci	Ramoval from Stata	Place of I cematary	Disposition (N , cramatory or	ama of othar pla	ce)	, Di	ata :	20c. Location -	City or To	wn, Stata
Balt	Departition imports any injury		21. Signature of Futural Service Line Ronal d	Wade, Direct	tor				re Str Board	eet,	Baltimo	ore,	Maryland212
			23a. Fan I. Entar tha disaase, or com book, or haart failura. List only	pplications that caused the dea	ith. Do no					piratory arm	ast,		Approximata Intarvai Between
N.	Physician			or a data or a dar i i i a.									Onsat and Death
	/Medical		Immediata Causa (Final disaasa or condition	a metasta	tric	Sal	Luci	~	alan	nd c	ance		Zyeons
3	Examiner		rasulting in death)			onsequance of		-)					0
	p #	ine		h									
0,	icate be executed physician end s the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (	or as a co	onsequance of	):						
68760,	hysich the bu	Medical	Causa (Disaase or injury that initiated evants resulting in death) Last	c. Dua to (	or as a co	nsequance of	):					+	
Box 6	E 0 8			d									
m	death ce	Icla	Part II. Other significant conditions of	Contributing to death but not re	eutina in	the underlying	COLLEG OF	en in Part I		23h Did to	hacco usa cor	stelbusto to	the cause of death?
P.0	es that the de igned by the a be detached in	Physician/	Tarti. Guidi aiginioant conditiona	contributing to obatif out not ra	auting in	ara arroarrying	oausa gii	all at Fait i.			• 2□ No	3 □ Prol	
	s tha	by P											7
of Vital Records,	been should	Completed b								24a. Was a perforr		CO	ara autopsy findings allable prior to impletion of cause death?
Be	0 - 0	E O								1□ Ya	is 2 No		□Yas 2□ No
ta	ician: The certificate rector, pag	BeC	25. Was casa rafarred to medical					26 Place	of Death (Ch				3 100 223 170
>	Physician: this certific ral director,	0	axaminar? 1 ☐ Yas 2 ☑ No	Hospital:	ER/Out	patient 3 0	Oth	or:		. /	nca 6 Oth	ar (Specif	V)
0	After thi	n: T	27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Th		28c. Injui			-	w injury occurr		,,
Ö	Attending I or death. ector: After by the funer	atio	1 Natural 5 Panding invastigation		, ,,,,	M		Yas 2□	No				
Division		Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined	28a. Placa of Injury - At the building, atc. (Special	noma, farr	n, streat, facto	ory, office			ocation (St City or Town		er or Run	Il Routa Number,
	Hospita 4 hours Funeral tely fille	edical C	29a. Certifiar (Check only one)	nysician: To the best of my kniminer: On the basis of examination and manner stated.	owledga, ation and/	daath occurre or invastigation	d at tha tir n, in my c	na, data and pinion, daat	d piace, and o	lua to tha ce tha tima, de	ausa(s) and ma ate and place, s	nnar as si	tated. o tha cause(s)
	To the vithin 2 To the comple	N N	29b. Signatura and titla of certifiar	- The true states.		2	9c. Licans	a number		2	9d. Data signed	d (Month,	Day, Year)
	⊢≯⊢ŏ		Matilda	4 S- 1-N			1	12(2)	50				
			30. Nama and addrass of person who	11.01.3	m 23a) /Y	vne Print)	ك	, -60	50			- 21	(71)
				complated cause of death (Ita	7 4	orle P	1	Tr	t. 0.000	200.	0.0 MD.:	2100	5 F
	Sta	ite	31. Data filed (Month, Pay Year)	Julie Dandon A	male BZ		1	Au	1				, , ,
	Registi		001001991	0									

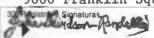


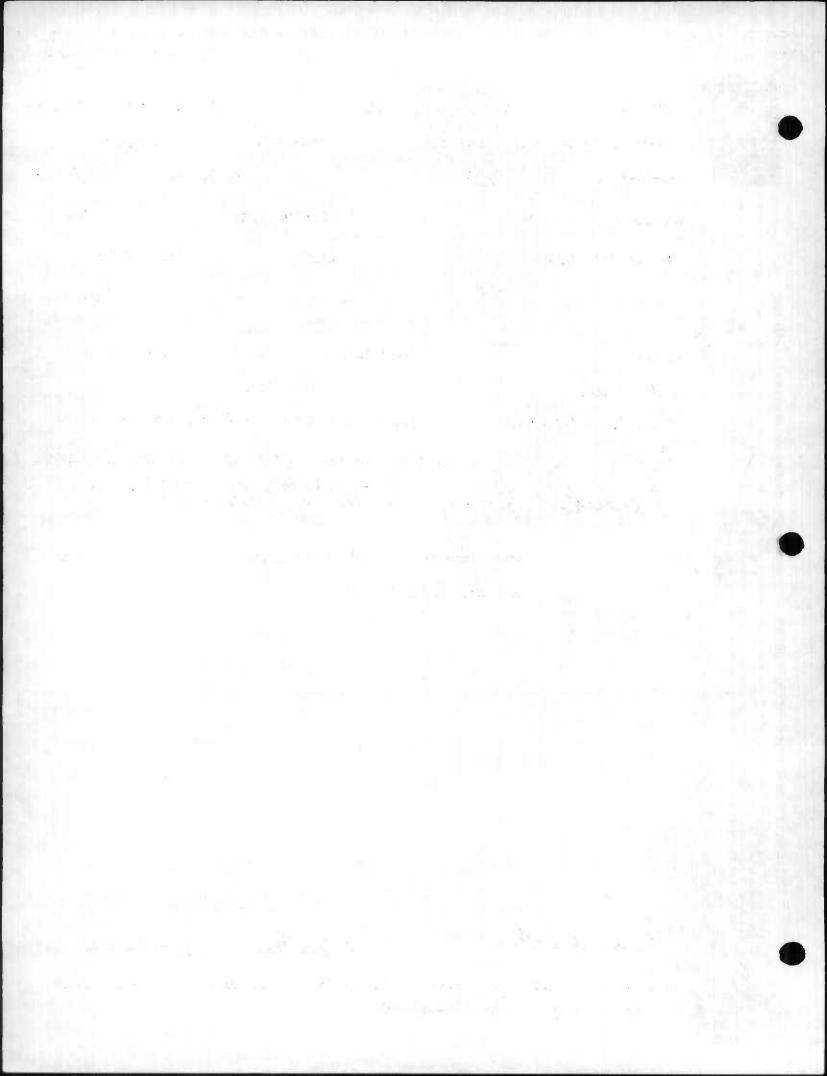
State of Maryland / Department of Health and Mental Hygiene 97 30633

					C	ertificate	of Death	7	Reg	J. No.		
H.J.		1. Decedant's Name (First, Middla, La	st)	17/0		DELE			2. Dete of Death			3. Tima of Death
Physicia /Medic		William	Thomas		V	THITE		- 4	October	7, 19	97	12:20 pm
Examin	_	4a. Fecility Nema (If not Institution, give	e street and number	7)			4b. City, T	own, or Loca	ation of Deeth	4c. County	of Death	
		Franklin Square	Hospital	Cent	er		Rose	eda1e		Ba1	timo	re
Funeral Director		5. Social Security Number 6. S 218-18-1487 Usual Rasidance of Dacedant	ex 7. A	ga (In yrs. 75	last birthda Yrs.	Months C	Year If Unda Hours	Min.	B. Data of Birth (Month, Day, 1 May 5,	(ear) 1922	9. Birthp Court Per	laca (Stata or Foreig try) LNS YLV anio
Marylend -f show	tor	10a. Steta 10b. County  Maryland	N/A	10c. City	y, Town or	Location	Baltimo	re Ci	ty		1	0d. Insida City Limit:
with the	I Direc	10e. Street and Number 919 Horner's Lan				10f. Zip Co	21205			g. Citizan of V		*
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dopartment of Health and Mantal Hygiena. Interfed other than "naturel", or itema 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at ODGs.	by Funeral Director	11. Maritel Status  1 Never Merriad 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forcas' 1  Yas 2  If Yas, Giva Year or Datas:	? !No	S. 13	. Was Decedan If Yes, specify	t of Hispanic O Cuban, Maxica			14. Rec	e - Amaric k, Whita,	an Indian,
within 72 ho ena. than "natur	Completed	15. Decedant's E. (Specify only highast gra	ducation da completad) Cotlega (1-4or	5.1	16a. Dec (Giv lifa.	edant's Usual C ra <i>kind of work o</i> DO NOT usa	occupation dona during mo ratired)	st of working	7	6b. Kind of Bu	usinass/ind	dustry
filed with Hygiena. ther than	Com	10 Years	Oologa (1-401	3+)	Tr	uck Dri	ver			Transp	porta	tion
be filed tal Hygie d other event,	Be	17. Fathar's Name (First, Middla, Last,					18. Moth	ar's Nama (	First, Middle, Ma	aidan Sumam	a)	
should be and Mantal I marked of	To	Andrew White					Mar	y Lew	es			
Lenti 2 sho Health and Im 27 is me ther traums		19a. informant's Name/Ratationship ( Betty E. White/							Routa Number, ltimore,			21205
72 4		20a. Mathod of Disposition			laca of Dis	position (Nama ematory or othe	of colace)		Data 20	Oc. Location -	City or To	wn, Stata
TY OF		1 XBurial 2 Cramation 3 4 Donation 5 Other (Sould)		3		n Cemet		/10/1	997	Baltin	nore.	Maryland
Desmit. Department of the control of		21. Signature of Funeral Service Licer				22. Nama end A	Addrass of Facili	ral H	ome of 1	Dundall	k, In	c.
	-	23a Phrt Enter the diseases or form	1 Jun	ung					alk, Ma		212	ZZ Approximata
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finel disease or condition		0		Bleed					1	thtarval Between Onset and Death  2 Days
		rasulting In daath)	a,			equanca of):						
p t	lue		b End St	age F	Rena1	Disease	9				i	
certificate be executed right physician and use as the buriel-transit	Examiner	Sequentially list conditions,	D.	_		equanca of):						
ding physician and sa as the buriel-transit		Sequantially list conditions, if any, laading to Immadiata causa. Entar Underlying Causa (Disaasa or injury	C									
physi the I	Medical	that initiated avants rasulting In death) Last		Dua to (or	as a conse	equence of):						
ding I	Me		d								i	
2 2 3												
2 6 8	by Physician	Part II. Other significant conditions of	ontributing to death t	but not rasu	ulting In tha	undarlying caus	sa givan in Part	1.		acco use cor		o the cause of death pably 4 - Unknow
e law requiras that the has been signed by th ge 2 should be detacht	Completed b				4				24a. Was an performe	autopsy ed?	ava	ara autopsy findings ailable prior to mplation of cause death?
0 5 0	E								1 ☐ Yas	2 No	1 [	Yas 2□ No
certificata	Be	25. Was case rafarred to medical					26. Pled	a of Death	Check only ona	)		
Physicien: this certific ral director,	To	axaminar? 1 ☐ Yas 2 ☑ No	Hospitat:	iant 2 🗆 I	ER/Outpati	ent 3 DOA	Other		a 5 Rasidan		ar (Specif	y)
the road		27. Manner of Deeth 1 Natural 5 Panding 2 Accident Investigation	28e. Data of Inju (Month, De	ury ay Year)	28b. Tima Injury	of 28c	Injury at Work? 1  Yas 2		d. Dascribe how	/ Injury occurr	ed	
or Attending I effer death. Director: After d in by the funer	Certification:	3 Sulcida 6 Could not be datarmined	28a. Ptace of In	jury - At ho tc. (Spacify	ma, farm, s	traat, factory, o	ffice	28	of. Location (Stree City or Town,		er or Rura	l Routa Number,
	edical	29a. Certifiar (Check only one) 1 Certifying Ph	ysician: To the best liner: On the basis of and manner st	of axaminat	viedga, das ion and/or i	th occurred at to	ha tima, data a my opinion, da	nd place, an ath occurred	d dua to tha cau I at tha tima, dat	isa(s) and ma a and place, i	nnar as st and dua to	ated. tha causa(s)
ompl	¥	29b. Signature and title of certifier	2.01			29c. L	icansa numbar		290	d. Data signed	d (Month,	Day, Year)
F S F O		Solo	ion			1	5466	32		10-7	1-9	7
6		30. Nama and addrass of person who	complated causa of	daath (Itam	23a) (Type	, Print)						
		Mario Cardillo N	1.D. 900	00 Fra	nklir	Square	e Drive	Ba1	timore,	Mary1	and	21237
5						e, Print)						

State Registrar

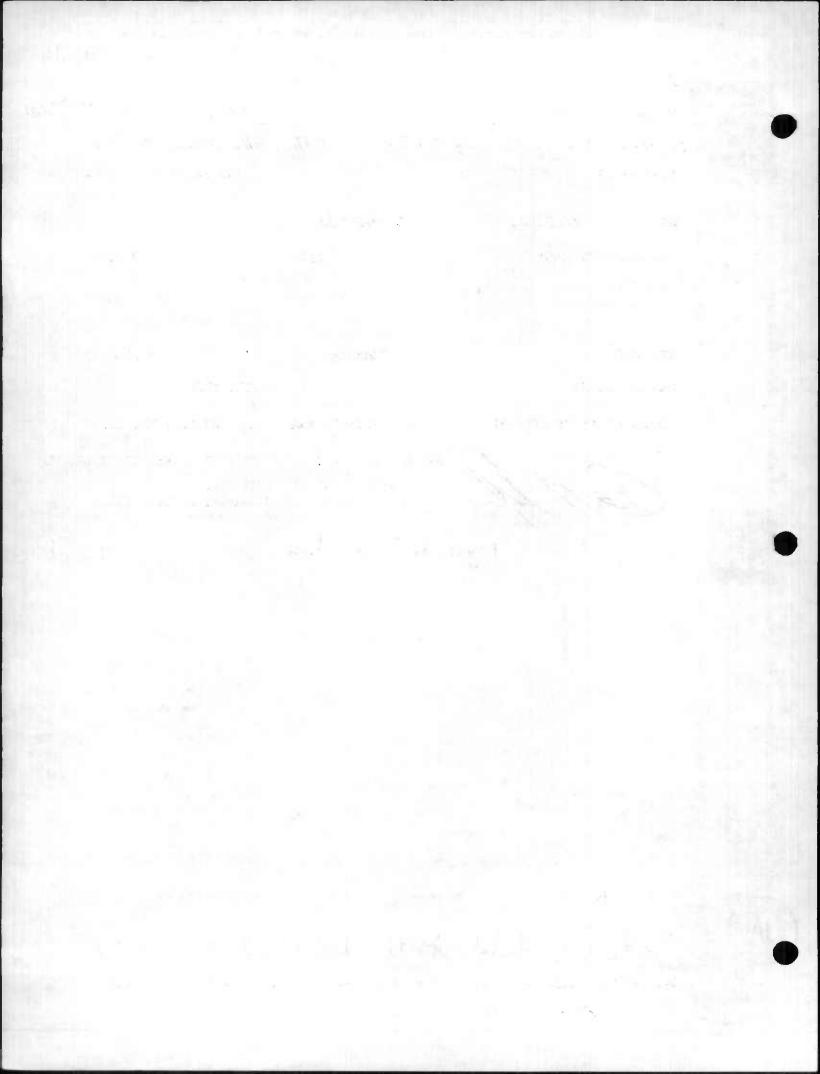
OCT 0 9 1997





State of Maryland / Department of Health and Mental Hygiene 0.7 3.06.3 la

	1 Decedent's	Neme (First, Midd	lo Last)		Certifica	ate of	Death	2. Dete of De	Reg. No.	, ,	0034
ysician	Mari							Month	Dey	Yeer	3. Time of Death
<b>Nedical</b>	11198		Weekly					Octobe		97	T. AN
aminer	4e. Fecility Nar	ne (ir not institutio	n, give street and numb				4b. City, Town, o	r Location of Deat			
		rickl	Illa Nurs	ing Cen	Ter	124	CATONSU	ille Ma	1. BAlti	more	2
rai	5. Sociel Secur		6. Sex 7.	Age (In yrs. last bir	Yrs. Month	er 1 Year s Days		n. (Month, De	th ey, Year)	9. Birthple Count	ece (Stete or Foreig ry)
or .	215-07- Usuel Residen			80	115.			JAN 22	,1917	MARY	LAND
	10a. Stete	10b. County		10c. City, Town	n or Location					10	Od. Inside City Limits
5	100	70.4	T TTYONE				_				1 ☐ Yes 2 ☐ No
5	MD 10e. Street end		ALTIMORE		CATONS		E				
ā					101. 2	ip Code			10g. Citizen of V	What Count	try?
rai		REENLOW H					21228			U.S.A	
Funeral Director	11. Marital Star		12. Was Decede Armed Force	es?	13. Was Dec	edent of ecify Cut	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No orto Rican, etc.)	- 14. Red Bled	a - America ck, White, e	
by F	1 Never	Married 2 Mar	If Yes, Give				Specify:		Specify	V: 1777	m.
P	3 LJ WIGOW	ed 4 Divorced	100.0.000							WILL	
Completed	(	15. Deceder Specify only highe	nt's Education est grede completed)	16e.	Decedent's Us (Give kind of v	vork dorie	ipetion a during most of w ad)	orking	16b. Kind of B	usiness/Ind	ustry
P P		Secondery (0-12)	College (1-4	or 5+)			90)			×	
	8TH GI		t and		HOMEMA	KER	1			MEMAK	ING
Be		me (First, Middle,	Lasi)					eme (First, Middle		10)	
P	SAMUEI	HUGHES					MA	ATTIE BRO	WN		
	19e. Informent	's Name/Reletions	ship (Type, Print)	19b.	Mailing Addre	ss (Stree	et end Number or F	Rural Route Numb	er, City or Town,	Stete, Zip	Code)
	RICHAI	MEEKLY	(HUSBAND)				ROAD -	CATONSVI	LLE, MD	. 212:	28
1	20a. Method of		o CD	comete.	Disposition (N y, cremetory or	eme of other ple	ece)	Dete	20c. Location -	City or Tov	vn, State
		on 5 Other (S	3 ☐Removel from Sta Specify)	ile	AWN CEM			10/9/97	MARRIO	TTSVI	LLE, MD
		Funeral Service		1					THUCKEO	11011	LLL, ID
		0,1	1/1/	i brote i i			ess of Facility INERAL HO				
	220 Po	ul /	- Jagen	and the death De-	4107 W	ILKE	ENS AVENU	E-BALITM	ORE, MD	2122	
	shock, or	heert feilure. List	only one hase on eed	h line.	iot enter the mi	JOB OF GY	ing, such as cardi	ac or respiretory e	rrest,		Approximate Intervel Between Onset end Death
	Immediete Cer	see /Final	ka	v 1.	DV		1				_ 1
	disease or con resulting in dec	dition	е.	yo caras	W-W	are	Mon				m mediat
5		,		Due to (or es e	consequenca of	f):					
Examiner			b								
xar	Sequentially lis if any, leeding cause. Enter I Cause (Disees	t conditions,		Due to (or es e o	onsequence of	·):					
	cause. Enter l Cause (Disees	Inderlying e or injury	C								
Physician/Medical	thet Initiated ex resulting in dea	ents		Due to (or es e c	onsequence of	):					
Me	0										
lan			d								
sici	Pert il. Other si	gnificant condition	one contributing to death	h but not resulting in	the underlying	cause gi	iven in Pert I.	23b. Did	tobecco use co	ntribute to	the cause of death
hy								10	Yee 2 No	3 Prob	ably 4 Unknow
by F											
8									en eutopsy		re eutopsy findings ileble prior to
oiet								penc	rmed?	com	pletion of cause eath?
Completed								40	Van med Na		
	25 Mac 2222	oforred to median						10		10	Yes 200 No
Be	exeminer?	eferred to medica	Hospital-	.311 1//-		Ot	28. Plece of De	eeth (Check only o	one)		
. To	1 Yes	2 No	1 Linpi		tpetient 3 C	JUA	4 Nursing	Home 5 Resi			)
ion	10 Natural	5 Pendir		Day Year) in	njury	28c. Inju		200. Describe	how injury occur	190	
Certification:	2 Accide		not he		М		Yes 2 No				
ŧ	4 Homic	datam	ined 288. Place of	injury - At home, far etc. (Specify)	m, street, facto	ory, office		City or To	Street and Numb vn, Stete)	er or Hurai	Houte Number,
ical	29e. Certifier (Check only	1 ☐ Certifyir 2 ☐ Medicai	g Phyelcian: To the be Examiner: On the besis	st of my knowledge, s of exemination and	death occurre	d et the ti	ime, dete end plac	e, end due to the	cause(s) end me	enner es ate	eted.
Medical	one)	1	end menner	steted.				,	orio ono procur,		
~	29b. Sighature	and title of sertifie	1 11	V 1.	0 2		se number	5	29d. Date algne	d (Month D	ley, Year)
	( 1/a	tall	(1) who	M M	V	U.	2336		10/	7/9	1
	30 Milme and 6	address of person	who completed cause of	of deeth (Item 23e) (	Type, Print)				-	-1-1-1	4
	DR. PA	TRICK W.	WHITE - 71	6 MAIDEN	CHOICE	LAN	E - CATO	NSVILLE,	MD 21	1228	
••	31. Dete filed (	Month, Day, Year)	3 <b>3</b> 0 Feq.	Stray's Signature							
te											



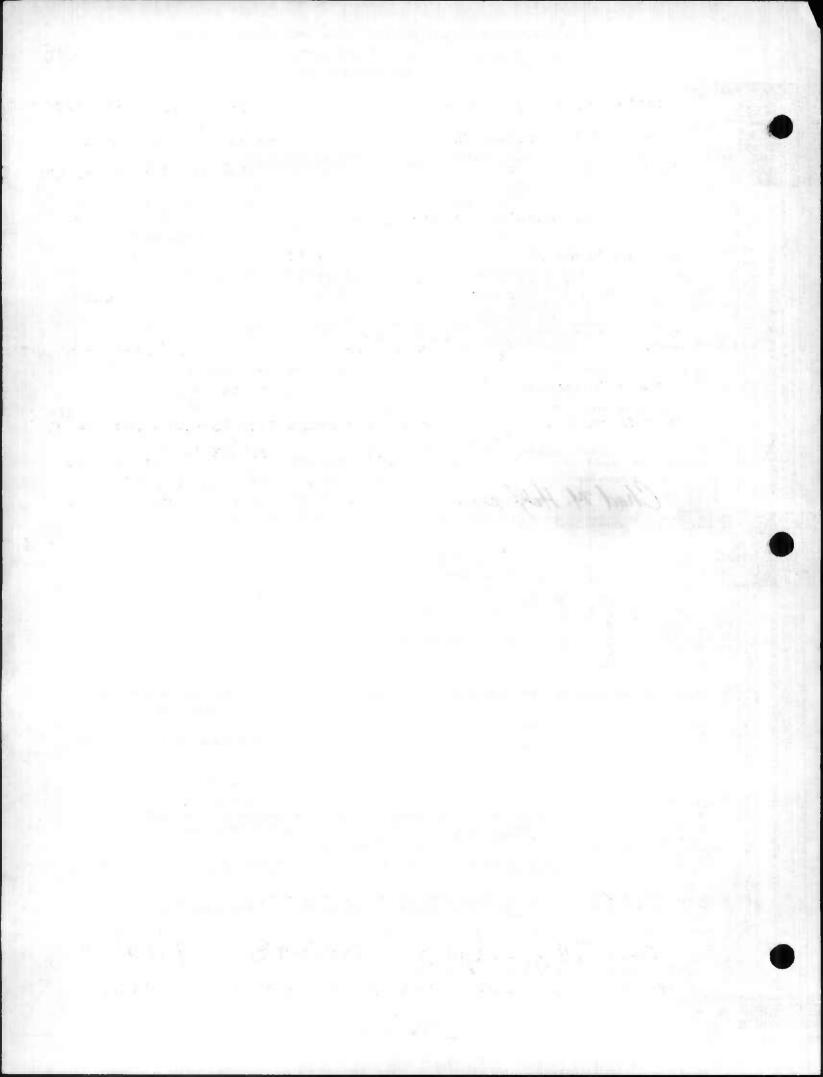
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State of Maryland / Department of Health and Mental Hygiene 9 7

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					(	Certifica	ate of L	Jeath		Reg. No.		
Physici	an	1. Decedent's Neme (First, Mid							2. Dete of De Month	eth	Yeer 3	. Time of Death
/Medic		Lillian Rho	-	Adams					Sept.	10	1997	5:00 a.
Examir	ner	4a. Feolity Neme (If not Instituti Corsica Hil	ls Nurs		ne		(	b. City, Town, or Centrev	ille	Queen		e's
Funeral Director		5. Sociel Security Number 218-76-4386	6. Sex 1 ☐ M 2 ☑	7. Age (In yrs	6 Yı	Month	ler 1 Year s Deys	Hours Min.	8. Dete of Bird (Month, De Feb. 1	Year) 191	9. Birthplece Country) Minr	(State or Foreign lesota
3 3		Usuel Residence of Decedent  10a. Stete 10b. Count	h	100.0	ity Town	or Location					104	Inoido City I lestro
sho	2	and the same of th	n Anne'			ville						inside City Limits  1 ☐ Yes 2 ☐ No
28a 1	ect	10e. Street end Number	n Aime	S CE	псте	1	∄ Zip Code			10- Cities of N		Λ
23a or	Funeral Director	205 Armstro	ng St.				21	617		U.S		
would receive the receive must be maryeard jene. Then "natural", or flems 23a or 28a-f show the Medical Examinar must be notified at	by	11. Maritei Stetus  1 Never Married 2 Me  **Widowed 4 Divorce	Arme	Decedent Ever in od Forces?  (es 2FNo s, Give or Detes:	J,S.		cedent of Hi pecify Cuba 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		e - American I ok, White, etc. : Whit	
natu	eted	15. Decede (Specify only high	ent's Education	ted)	16e. D	ecedent's Us	suel Occupa	tion uring most of wor	rkina	16b. Kind of Bu	usiness/indust	ry
1 Table 1 Table 1	Completed	Elementary/Secondery (0-12)		ge (1-4or 5+)		im. DO NOT nemake		aring most or wor		omesti	c/Own	Home
d other	Bec	17. Fether's Neme (First, Middle						18. Mother's Ner	ne (First, Middle,	Melden Sumer	10)	
marked umatic e	To	Robert Simp	oson					Bessie	May Pe	ence		
and le ma	.	19e. Intormant's Name/Reletion		)	19b. A	Melling Addre	ss (Street a	nd Number or Ru	ıral Route Numbe	r, City or Town,	Stete, Zip Co	<sup>de)</sup> 21617
f Health and Mental Hyg tem 27 is marked other other traumatic event,		John Adams/S	Son		200	Boro	lling	ton Fa:	rm Lane	Centr	evill	e.MD
nent of H int: If iter iry or oth		20e. Method of Disposition 1 X Buriel 2 ☐ Cremetion	3 □Removel f		cemetery,	cremetory of	eme of r other pleci		Dete	20c. Location -	City or Town.	Stete
men ant: lury		4 Donetion 5 Other (		Sp	ring	Hill		tery	56.15,1	Eas	ton,	MD
Department of Health Important: If Health any Injury or other to once.		21. Signeture of Funerel Service	Licensee,	sho. i		22. New 408 S	and Addres	Funera.	Home;	Helfe	nbein	., &
		23a. Pert1. Enter the disease, of shock, or heert teilure. List	or complications t	hat caused the dea	th Dono	t enter the m	ode of dving	ercy Si	correction a	revill		Z161/ proximate
e ettending physician end od for use es the burial-transit	Medical Examiner	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that intileted events resulting in death) Lest	c			nsequence of	f):	- FA	TLUE	25		
ettendir I for use	lan		0									
thed t	Physician/	Pert II. Other significant condit	lons contributing	to death but not re								
50	Ph				suiting in t	he underlying	cause give	n in Pert i.	23b. Did 1	obacco use cor	ntributs to the	causs of death?
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been signer should be d	pleted by				suiting in t	he underlying	g cause give	n in Pert i.	1 🗆 1	a said	3 Probabl	4 Unknown  Butopsy tindings ble prior to betion of cause
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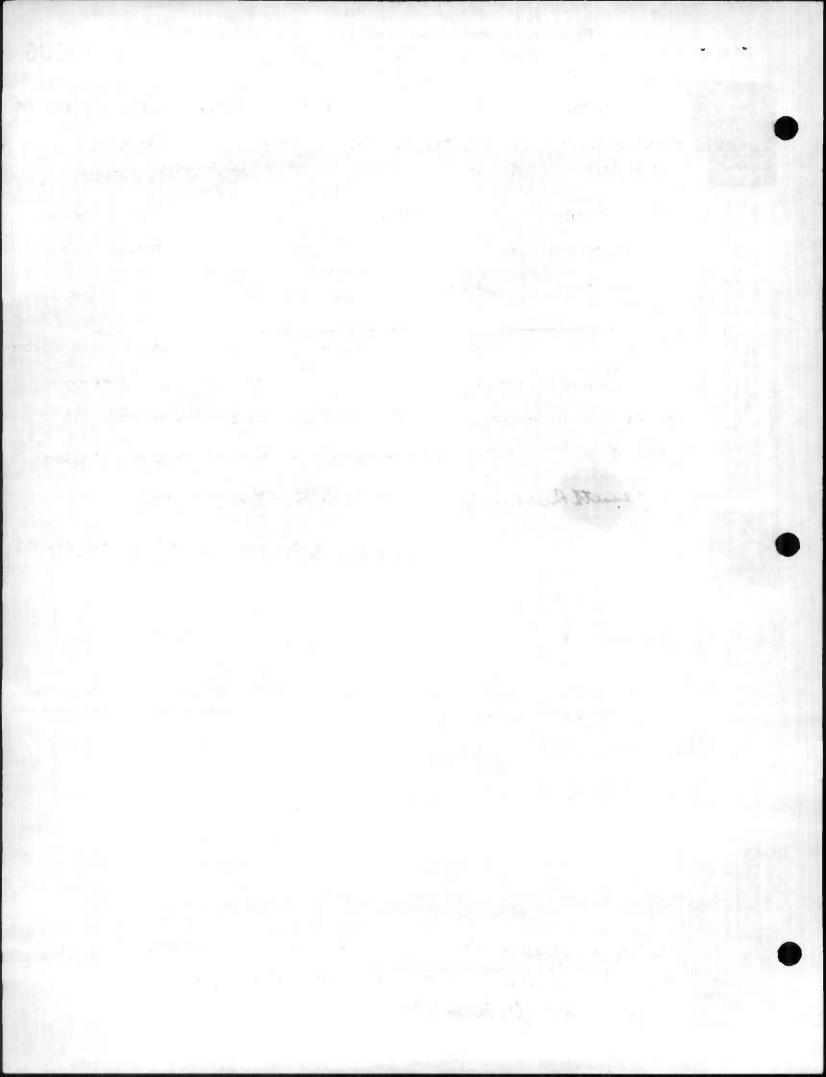
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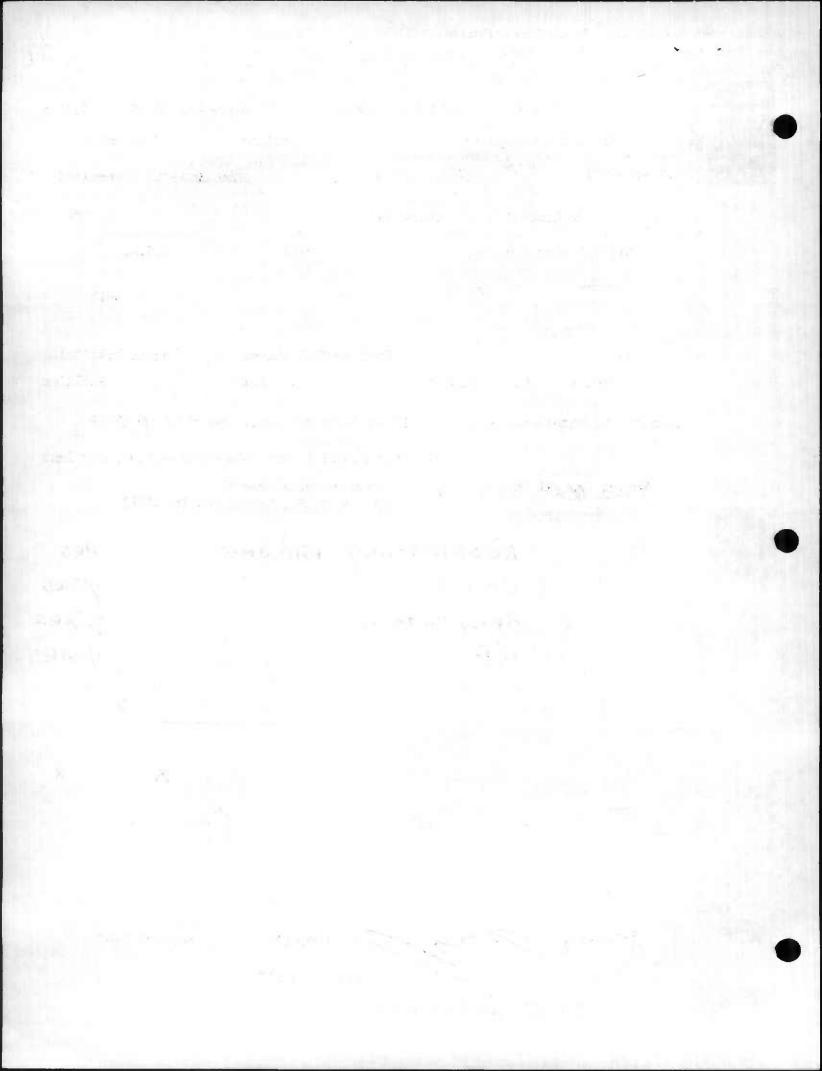
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uneral		5. Sociel Security Number 6. S 221–30–2528	Sex I□M 2AIF	7. Age (In	yrs. lest birthday Yrs.	/) If Under 1 Months	Deys	If Under 2 Hours	Min.	8. Date of Big (Month) Di Aug. 25	th ay, Year)			or Foreign
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show od et		10e. Stete 10b. County		100	. City, Town or L	ocation							10d. Inside	City Limits
fled	to	MD Carolin	ıe		Dente	on							TEYE	s 2 No
r then "natural", or items 23s or 28s-f sho the Medical Examiner must be notified at	Director	10e. Street end Number				10f. Zip (					10g. Citizen		ntry?	
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Burne		19a. Informent's Name/Relationship (								I Route Numb				21
10		Mrs. Carol Bradle	y-siste					cove	.Ka.,	East				31
any injury or all		20e. Method of Disposition  1 Buriai 2 Dicremetion 3 D	Removel from 5	State		emetory or oth	er pled			Dete	20c. Locatio			
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		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events	C		to (or es e conse							1		
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complately mied in by me	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Pleca	of Injury -	At home, farm, s					28f. Location	Street end Nu	m <i>ber</i> or Rur	al Route Nu	ım <i>ber</i> ,
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		30. Name end eddress of person who												-
		GARY SPROUSE,	M . D .	2108	DIDON	ATO D	RIV	/ E C	HES	TER.	MD 21	619		
State	6	GARY SPROUSE,  31. Date filed (Month, Dey, Year)			ignape dall	ATO D	RIV	/E C	HES	TER,	MD 21	619		



30637 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

acility Name (If not Institution  511 Go  cial Security Number  14-10-0967  Residence of Decedent  State 10b. County  MD Dorn  Street and Numbar  511 Gold  artial Status  Never Married Mai  Widowed 4 Divorced  (Specify only higher  mantary/Secondary (0-12)  11  athar's Nama (First, Middla, Daniel  Informant's Name/Ralation  Wrence E. Ba  Method of Disposition  Burial 2 Cramation  Donation 5 Other (Signature of Funeral Service)	MILDRED on, give street end in oldsboroug 6. Sax 1	Ave.  7. Age (in yrs 76  10c. C  Ave.  cedent Ever in terrores) 224 No inventor State  Datas:  1)  (1-40r 5+)  Lowe  causad the daa aach line.	Isas birthday) Yrs.  Ity, Town or Lo Cambrid  J.S. 13.  16a. Decer (Give life.)  19b. Mailit  511  Place of Dispo cometery, crer rcheste	was Decedar 10f. Zip 0  Was Decedar 1 Yas, specification 1 Yas 2 1  dent's Usual kind of work 20 NOT use 2 1  Good Signary Address (  Golds: sitton (Nemetory or other Memory) or other Memory 2 Normal and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 Nama and 1 Normal 2 N	Code 210 Cod	nbride dar 24 Hrs. rs Min.  513  Origin? (Sp. cen, Puerto in Ave.  Park 9  Park 9	8. Date of Bir (Month, De Nov 22  Pecify Yes or No Ricen, etc.)  Ring  Per e (First, Middle, Ma  al Routa Number Cambridge  2 Cambridge	Day Der 26 1 1 4c. County Dor Thy, Year) 2 1920  10g. Citizen of V U.S.  14. Race Blace Specify  16b. Kind of Bi  Stat Maiden Suman  er, City or Town, Cidge MD 20c. Location- Cambrid	9. Birthp Coun Max  What Coun A.  Per - Amaricck, White, W	leaca (Steta or Foreignity)  Fyland  Od. Inside City Limits  Fig. 2 Noticy?  Indian, etc.  Lte  dustry  Spital  Phillips  Code)  3  wwn, Stata
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Wrence E. Ba  Method of Disposition  Burial 2 Cramation  Donation 5 Other (Signature of Funeral Service  Part1. Enter the disaase, o shock, or haart failure. List  didate Cause (Final isse or condition	Thes—husb  3 □Removal from Specify)  e Licensee  Licensee  C J  or complications that st only ona causa on	Do Do Ceusad the daa aach line.	511 Place of Dispo cemetery, crer rcheste	Golds: esition (Nementory or other Memons) Nama and	borough e of her plece) horial l	Park 9	Cambr Date 9-28-97	ridge MD 20c. Location - Cambrid	2161 City or To	3 own, Stata
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Part1. Enter the disaase, o shock, or haart failure. List ediate Cause (Final ise or condition	or complications that at only one cause on	ceusad the daa aach line.	th. Do not ent	er the moda	of dving, such	. Can		Day Year ber 26 1997 th 4c. County of Death Dorcheste inth Act County of Death Dorcheste inth Poy Part 1920  10g. Citizen of What County U.S.A.  11g. County Of County U.S.A.  11g. Citizen of What County U.S.A.		
ise or condition	R					as cerdiac	or raspiratory a	MD 216	13	Approximata Interval Between Onset and Death
	C		PATO or as a consact		FA	100	RE			HRS VEARS
antially list condiflons, , laading to immediata e. Enter Underlying e (Disease or Injury nitiated events			or as a consec	( A						YEARS YEARS
ntiated events ting in death) Last	l R	Due to (	or as a conseq	uence of):						YEARS
. Other significant conditi	iona contributing to	death but not re:	sulting in the u	ndarlying cau	use given In P	art I.	23b. Dld	tobacco uae co	ntributa to	the cause of deat
							10	Yee 2 No	3 Prot	bably 4 🗆 Unkno
							24a. Was perfo	an autopsy rmad?	COL	are autopsy findings ailable prior to mpletion of causa death?
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ras case referred to medical caminer?  ☐ Yes 23-No	Hospital:	Inpafiant 2	ER/Outpatier	nt 3 DOA	Other		10		er (Specifi	v)
anner of Death  Natural 5 ☐ Pendin ☐ Accidant Investi	28a. Date (Moi	of Injury		-	c. Injury at Work?					
☐ Sulcide 6 ☐ Could	mined 200. Plac			eet, factory,	office		28f. Location (: City or To	Street and Numb vn, Stete)	ber or Rura	i Routa Number,
Certifier Check only one) CertifyIr	Examinar: On the l	basis of examina	owladga, daath ation and/or Inv	occurred at restigation, li	t tha time, date in my oplnion.	and place, death occur	and due to the red at the time,	cause(s) and ma data and place.	anner as st and due to	ated. the cause(s)
Signature and title of certifie	er .	en	, /	-						
		CO. C.	Contract of the contract of th		100 (	01610				
a a c C C C C C C C C C C C C C C C C C	as case referred to medicaminer?  Yes No Inner of Death Natural 5   Pendinvesi Accidant Invesi Sulcide 6   Coulc deten Homicide Certifier Check only 2   Medica ignature and title of certifier ma and address of persor	as case referred to medicel aminer?  Yes 25 No	as case referred to medicel aminer?    Yes	as case referred to medicel aminer?    Yes	as case referred to medicel aminer?    Yes	as case referred to medicel aminer?  Hospital: 1 Inpafiant 2 ER/Outpatient 3 DOA Other: 4 Injury of Injury at Work? Accidant Investigation Investigation Investigation Investigation Accident Sulcide Homicide  Homicide Sertifying Physician: To the basis of examination and/or investigation, in my opinion, and manner stated.  Sertifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, and manner stated.  Base Case referred to medical 26. Place of Injury 2 ER/Outpatient 3 DOA Other: 4 Injury at Work? M 1 Yes 2 28b. Time of Injury 4 Injury 2 At home, farm, street, factory, office  Sertifying Physician: To the basis of my knowladga, death occurred at the time, date of the basis of examination and/or investigation, in my opinion, and manner stated.  Base Case referred to medical 28c. Injury at Work? M 1 Yes 2 28c. Injury at Work?	aminer?   Yes 25 No	as case referred to medical aminer?    Yes	as case referred to medical aminer?    1   Yee   2   No	as case referred to medical animer?  24a. Was an autopsy performad?  24b. Was an autopsy performad?  24b. Was an autopsy performad?  24c. Place of Death (Check only one)  1   yes 2   No



State of Maryland / Department of Health and Mental Hygiene

30638

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death r 29 1997 Month **Physician** BROOKS GOLDA VIRGINIA 7:35 pm September /Medical 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Dorchester Dorchester General Hospital Cambridge 5. Sociel Security Number If Undar 1 Yaar If Undar 24 Hrs. Months Deys Hours Min. 8. Data of Birth (Month, Dev. Year) 9. Birthplace (Stete or Foreign Country)
Sept. 04 1915 Maryland 7. Aga (In yrs. last birthday) **Funeral** 10 M 200 F Deys 82 220-26-2047 Yrs. Director Usuel Residence of Decedent 10a Stata 10b County 10c. City, Town or Location 10d. inside City Limits rai', or items 23s or 28s-f shor Exerciper must be notified at Cambridge TANAS 2□No MD Dorchester Director 10f. Zip Code 10e, Street and Number 10g. Citizen of Whet Country? 21613 414 Maryland Ave. U.S.A. Funeral Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Bleck, White, etc. filed within 72 hours after 1 Never Married 25 Married 1 Yes 2 No Specify: "natural", or white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) office manager wholesale grocer permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, I. 17. Fathar's Name (First, Middla, Last) 18. Mothar's Neme (First, Middle, Meiden Surnama) Be Sadie Todd unknown 19e. Intorment's Neme/Raletionship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Maryland Ave., Cambridge MD 21613 Mr. Archie S. Brooks-husband 20b. Pieca of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removel from Stete Old Trinity Churchyard 10-2-97 Church Creek Maryland 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funarei Service Licensee 22. Nama and Addrass of Facility
Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Ceuse (Finei diseese or condition resulting In deeth) /Medical Examiner Examiner Obstructive attending physician end for use as the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence ot): Hermanon Division of Vital Records, P.O. Box 68760, uncal Physician/Medical Due to (or es a consequenca of): been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? HTN 3 Probably 4 Unknown 1 ☐ Yee 2 No þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? Is certificate h 2 No 1 Yes 20No Hospital or Attanding Physician:
 Hours after death.
 Funeral Director: After this certifical
 House of the funeral director; 25. Was case reterred to medical Be 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) Malinpatient 2□ ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signeture and title of certifiar 29c. Licensa number 29d. Date signed (Month, Dey, Year) D0050987

State Registrar

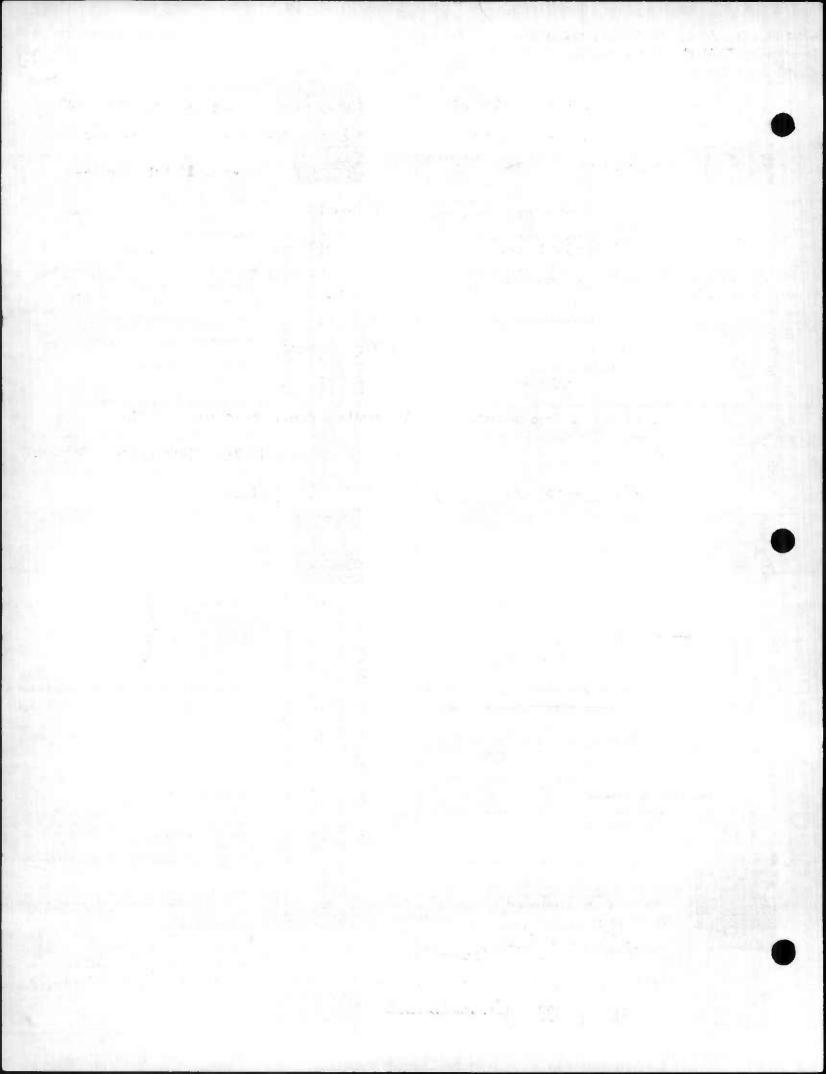
Am ED

31. Data tiled (Month, Dey, Year) 32 Registrar Signature

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

105 Aurora Street Cambridge mo21613

20

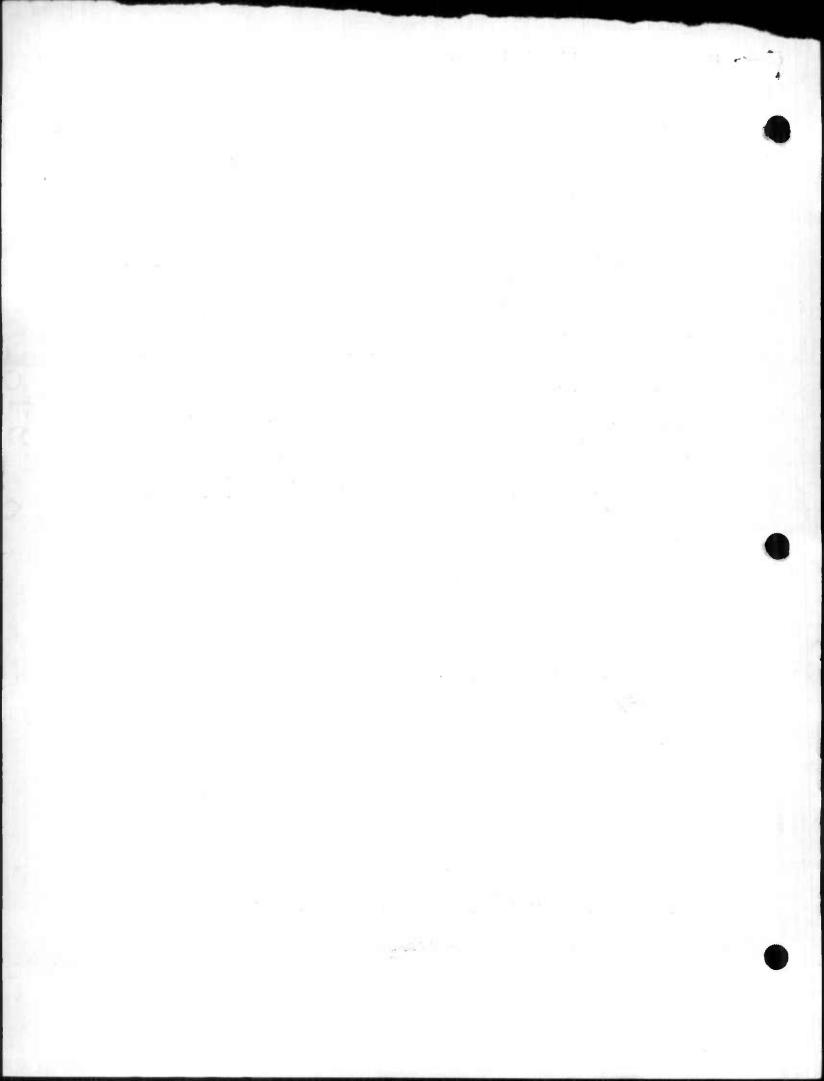


TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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1 - FOR STATE REGISTRAR		STATE OF MARYL					EALTH AND I	MENTAI	HYGIENI REG. NO.	E					
1. DECEDENT'S NAME (First	, Middle, Last)								OF DEATH			3. TIME OF DEATH			
MARGARET	REBECC	A BATLEY						Sept. 30,1997 YEAR 3:30 A							
4. SOCIAL SECURITY NUMBER	- 1		(In yrs. lest		IF UNDER 1 Y	_	IF UNDER 24 HRS.	7. DATE	IPLACE (State or Foreign	,					
216-10-0378		M 2 F 85		YRS.		AYS OWN OF	HOURS MIN.	June	Virginia EATH						
Clearview N					Hage					Wash					
RESIDENCE OF DEC	CEDENT														
toe. STATE	10b. COUNTY				TOWN OR I		ON					10d, INSIDE CITY LIMITS?			
Maryland	Washing	gton		над	ersto	-						1 YES 2 NO			
9946 Downsv			ZIP CODE 1 740				S.A.								
tt. MARITAL STATUS	18	. WAS DECEDENT EVER					NDENT OF HISPAN			or No		E - American Indian,			
1 Never Married 2 3 Wildowed 4 Divo		FORCES? 1 YES		0			cify Cubari, Mexica 2 NO Specify		Rican, etc.)		Spec	ock, White, atc.  White			
15. DEC	EDENT'S EDUCAT	ION	16a. DE	CEDENT'S U	SUAL OCCL	PATIO	N	16b.	KIND OF BUS	INESS/INDU	JSTRY	W112 CC	_		
(Specify online) Elementary/Secondary (I	y highest grade cor 0-12) (	npleted) College (1-4 or 5 +)	life.	ve kind of wo Do NOT use	retired.)		t of working								
		2	Pay	roll	Clerk	2		A	ircraf	t Mfg	. C	ompany			
17. FATHER'S NAME (First, A							16. MOTHER'S NA								
John Willia		Y					Ellen V								
Rebecca A.		/ Ni oco					nia Ave.					and 21742			
200. METHOD OF DISPOSIT								-		CATION — C					
1 Surial 2 Crematic	on 3 🗆 Ramova	of from State 20	netery, crei Lue I	NODATE OF Oth Ridge	er place) Ceme	ter	y Oct. 3	0AT				aryland			
21. SIGNATURE OF FUNERA	L SERVICE LICEN				22. NA	ME AN	D ADDRESS OF FA	CILITY		] Hom					
11 Jeans		Fin			133	31 ]	as A. Fi Eastern	Blvd	. N. H	agers	tow	n,MD 2174	42		
23. PART I. Enter the shock, or h immediate CAUSE (Fit disease or condition resulting in death)  Sequentielly list condition if smy, leading to immediate. Enter UNDERLY CAUSE (Disease or injutted initiated events)	tions, dilate iNG	Construction of the course on the course of the course on the course of	ive a consecutation a consecutation	Hear DUENCE OFF	t Fa : : .sease	il		n as cerc	nsc or raspi	ratory srre		Approximate Interval Believe Onset and De 3 month 5 years 30 years	ns S		
PART II. Other significant valve	ant conditions of replace	ement; imp	Lante	d car	diac	ра	cemaker		24a. WAS AN PERFOR 1  YES 2	IMED?	241	WERE AUTOPSY FINDIN AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?			
	JSE CONTRI	BUTE TO CAUSE	OF DEA	TH YES	S   NO				type 			1 YES 2 NO			
25. WAS CASE REFERRED TEXAMINER?	F	IOSPITAL:			QTHER:										
1 TYES 2 X NO	1	Inpetient 2 ER/Ou	ipetlant 3	DOA 28b, TIME		g Home	5 Residence		r (Specify) SCRIBE HOW I	NUMBY OCC	HIBED				
Netural 5	Pending Investigation	(Month, Day, Year)		INJU	IRY	WOI	RK?	200. DE	JUNIOE HUW I		JUEN				
a Classica	3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, farm, street, factory, of building, atc. (Specify)							ffica 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
		AN: To the best of my kno On the besis of examinati										a) and manner as stated	d,		
29b. SIGNATURE AND TITLE	E OF CERTIFIER	.//	0				29c. LICENSE NUI	MBER		29d, DATE	signer	3 (Mgrth, Day, Year)			
	deey	Mont 1	-				D07857			19	120	197			
30. NAME AND ADDRESS OF EDSON B. MOC		COMPLETED CAUSE OF D 1190 MT. AETN				N, M	MARYLAND 2	1740		-/	1	7			
31. DATE FILEO (Month, Day,	2 1997	32. REGISTRAN'S SHO		Books						·					



State of Maryland / Department of Health and Mental Hygiene 30640 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Sept. Dey 1997 Year **Physician** 25, Julia Richards 8:40 P. M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Williamsport Washington Homewood Retirement Center | H Under 1 Yeer | H Under 24 Hrs. 8. Dete of Birth (Months, Deys Hours Min. Sept. 23, 1923 9. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. iest birthdey) **Funeral** 1□M 2ÅF Yrs. Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Hagenstown Maryland Washington 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 21742 USA 13135 Blue Ridge Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No if Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) real estate agent real estate 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Department of Health and Mental Important: If itsm 27 is marked or any Injury or other traumatic eve Taylor Schoonover Richards Summa William Moffett 19e. Informent's Neme/Relationehlp (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Hagerstown, Maryland 21742 13135 Blue Ridge Road <u>Charles J. Baish III</u> 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 9/29/97 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21./Signature of Funeral Service Licenses 22. Neme end Address of Fecility Gerald N. Minnich 305 N. Potomac Street 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate Approximete tnterval Between Onset and Death **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Due to (or es a consequenca of): **Examiner** physician and s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 (No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 Satural after death.

Director: Aft
d in by the fur 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Sulcide Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the cause(s) and menner as stated.

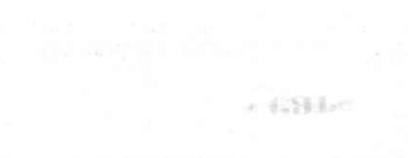
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and menner steted. To the Hosp within 24 hou To the Funer completely fil Medical 29a, Certifier 29b. Signature and title of popular 29c. License number 29d. Dete signed (Month, Dey, Year) ampleted cause of deeth (Item 23a) (Type, Print) State

Registrar

Attending

Hospital or • Funeral

d 2 should be filed within 72 th and Mental Hygiena.



#### 1. Decedent's Nama (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, giva straet and number) **Examiner** 5. Social Security Number **Funeral** Director 220-28-7809 Usual Residence of Decedent 10a. Stata It. Pages and 2 should be filed within 72 hours after death with the Marylar many of the sith and Mental Hygiene. Turit It item 27 is marked other than "natural", or items 23a or 28af show highly or other traumatic event, the Medical Example rount to notify a Director MARYLAND 10e. Street and Number Funeral 3altimore, Maryland 21215-0020 þ Completed Lo Injury or Department Importment Importment Info

EUGENE

10b. County

WASHINGTON COUNTY HOSPITAL

WASHINGTON

1 □ M 2 🖾 F

BUSSARD

7. Aga (In yrs. last birthday)

64

Yrs

10c. City, Town or Location

MERLE

27 POTOMAC STREET 21713 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedant Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 1 St Yes 2 No 1952-If Yes, Give Year or Datas: 1956 1 ☐ Never Marriad 2 ☑ Married 1 ☐ Yas 2 No 3 ☐ Widowed 4 ☐ Divorced Specify WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 9 JET ENGINE MECHANIC AIR NATIONAL GUARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) FRANKLIN HOWELL BUSSARD BERTHA FLORENCE FERGUSON 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) NORMA E. BUSSARD/WIFE 27 POTOMAC STREET, BOONSBORO, MARYLAND 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BOONSBORO CEMETERY 9/28/97 BOONSBORO, MARYLAND Funeral Service Cicensee 22. Nama and Addrass of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Pall1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 00 Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Due to (or (s a consequence of) Examiner ician and burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial Physician/Medical Due to (or as a consequance of): BUSSARD, MERLE Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Nos 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? Completed complation of causa of death? certificate dne 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation After 1 Natural 2 Accident or Attending 1 TYes 2 No death. after death Director: 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D' complately filled i 29a. Certifie 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end manner es steted. Medical 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Nemp end address of person who completed cause of death (Item 23a) (Type, Print) Hamdan MD. nd Ave: Hagerstown, MD 363

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Year

10f. Zip Code

Months

Days

2. Date of Death

8. Data of Birth (Month, Day, Year) NOV. 23, 1932

4b. City, Town, or Location of Death

HAGERSTOWN

If Under 24 Hrs. Hours Min.

**BOONSBORO** 

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1X Yes 2 □ No

MARYLAND

Year

24

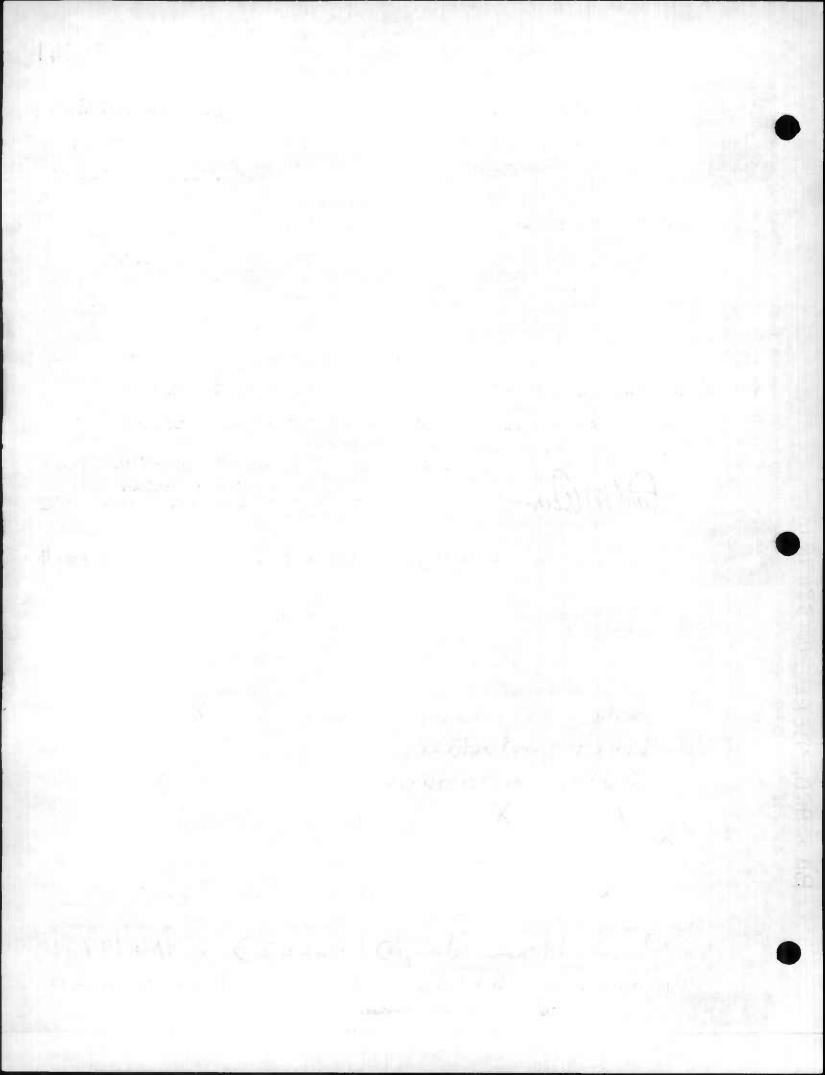
4c. County of Deeth

10g. Citizen of What Country?

1997

WASHINGTON

State Registrar 31. Date filed (Month, Day, Year) SEP 26 1997



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 0 6 4 2

ysician	1									Death			Reg. No	0.			
vsician		<ol> <li>Decedent's Name (First, Min</li> </ol>								2. Date of D	eeth		W. C.	3. Time o	of Death		
Medical		DORA	BEDELL						Sept.	26	6 1997 2		2:30	p.m.			
aminer	4	le. Facility Name (If not institu	tion, giv	e street and nu	et and number) 4b. City,					4b. City, Town, or Location of De				of Death		-	
	ı	1016 Vine S	eet						Lusb	У			Calvert				
eral ctor	8.5	5. Social Security Number 085 24 4546	6. 5	Sex I□M 2⊠TF	7. Age (la	n yrs. last birtl	hday) (rs.	if Under Months	1 Yeer	If Under Hours	4	8. Date of B (Month, L	irth Dey, Year	7)	9. Birthp	place (State	or Foreign
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rms 23s or 28s-f show r.must be notified at neral Director		10a. Stete 10b. Cour			10	Dc. City, Town	or Loc	ation							1	Od. Inside C	ity Limits
natural, or items 23s or 28s-f show dical Examiner must be notified at sted by Funeral Director		Maryland Calv	ert		1	Lusby										1 🗌 Yes	2 <b>N</b> No
	1	10e. Street and Number 1016 Vine Street					٠	10f. Zip		557					of What Country? States		
	1	11. Marital Status	12. Was Decedent Ever In U.S.			r In U,S.	S. 13. Was Decedent of Hispanic Origin? (Sp				pecify Yes or No- 14. P			Rece - American Indian,			
		1 Never Merried 2 M 3 Widowed 4 Divorce	Armed Forces?  1 Yes 2 Tho If Yes, Give Year or Dates:				☐ Yes		Specify:		Ricen, etc.)	en, etc.) Black, W Specify: W					
Completed	-	15. Deced	Education 166			16e. Decedent's Usuei Occupation					16b. F	Kind of B	usiness/in	dustry			
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# Io		12				housewife				own h			name				
Be (	1	17. Father's Neme (First, Midd	)			18. Mother's Name			ne (First, Middle, Malden Su		n Suman	Sumame)					
		Frederick Nagele		Flora Sig					pal								
traum.		19e. Informent's Neme/Relation Scott Nance — sci		Type, Print)		19b.						ral Route Number, City or Town, Stete, Zip Code) arryland 20610					
y or other tr	2	20e. Method of Disposition  1 ☐ Burlai 2 ☐ Crematio  4 ☐ Donation 5 ☐ Other			State N	20b. Place of cemeter.	Dispos	atory or o	ne of other pla	Sept Ervio	27	7, 1997 20c. Location - City or Town, State Alexandria Virginia					
any injury or	-	21. Signature of Funeral Service					22.	Neme an	nd Addre	ss of Facili	tv						
any l		RE		120							Rat	isch Fun					
	+	23a Part1 Enter the diseases	OY OOM	oliontions that	Baucod the	doub Do n						rt Repub		aryla	nd 206		
		<ol> <li>Pert1. Enter the disease, ahock, or heart failure. L</li> </ol>	ist only	one cause on	eech line.	death. Do n	Ut elite	r trie mod	ie or ayı	ig, such as	Cardiac	or respiratory	arrest,			Approxima Interval Be	(e)
hysician /Medical xaminer	Т															Onset and	Deeth
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Physic		LORRAINE MARY	BUCHANAI	UCHANAN						September 30 1997				
/Medi Examir		4a. Fecility Neme (If not institution, g	ve street end number	)			4	b. City, Town, or I			unty of Dea	ath		
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Funeral	Г	Social Security Number     6.	Sax 7. A	ge (In yrs.	last birthday)	If Undar 1 Months D	Yaar Deys	If Undar 24 Hrs. Hours Min.	8. Deta of Bi (Month, D				State or Foreig	
Director		Usuel Residence of Decedent 53 September 1,1944 New											York _	
the Marylan 28s-f show notified at	Director	Maryland Charle	s		ian He	ad						12	ide City Limita ¶Yas 2 □ No	
or 2	吉	10e. Street and Number				10f. Zlp Co	oda			10g. Citizer	of What C	ountry?		
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72 hours after death with the Maryland natural', or items 23a or 28s-1 show leas Example must be notified at	by Funeral	11. Marital Status  1 □ Never Merried 2 □ Married  3 ☒Widowed 4 □ Divorced	Armed Forcas'	1 ☐ Yes 2 XNo tf Yas, Give 1 ☐ Yes				spanic Origin? (Sin, Maxicen, Puart Specify:	pecify Yes or No o Rican, atc.)	Specify:			ita, atc.	
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d 2 d d d d d d d d d d d d d d d d d d				Con					THI FROM THE	or, only or re	, Ototo,	ZIP GOGE)		
permit. Pages 1 end 2 Depertment of Health a Important: If Item 27 is any injury or other tra		Peter Anthony Buc 20e. Method of Disposition	nanan	Son 20b. I		as #1			Dete	20c. Locat	ion - City or	r Town, St	ete	
or of H		1 ☑ Burial 2 ☐ Crametion 3			cematery, cre	metory or otha	ar piec	October:	3,1997					
semil. Pages 1 e. Septiment of Hee mportant: If Nem iny Injury or other age.		Pisgan Nazarene Church							n.	Pisga	h, Ma	rylar	nd	
mad out		21. Signeture of Funarel Service Licensee  22. Name end Addrass of Facility Williams Funeral Home, P.A.  4270 Hawthorne Rd., Indian Head, Md. 20640  23a. Part1. Enter the disease, or complications that eaused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Betwoen the constant of the complete of the comple												
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		23a. Part1. Enter the disease, or con shock, or he av feilure. List onl	nplicetions thet cause y one cause on each I	d the dee	th. Do not en	er the mode o	of dylne	, such as cerdiac	or respiretory	arrest,		Appro	ximate al Between	
Physician /Medical Examiner		Immediate Cause (Fine)	Lung									0.130	and Death	
LAGITITIE	<u></u>	resulting In deeth)	0.	Due to (	or es a conse	quence of):								
ate be executed sysician and he burial-transit	Examiner	Sequantielly list conditions,	b	b. — Due to (or as a consequence of):										
be executionand international	E	Sequantielly list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events												
ate be ex hysiclan the burial	lical	thet initieted events resulting in death) Last	uance of):							_				
S G S	Mec											1		
ath cert	an		0									!		
e death he atter	Physician/M	Part II. Other significant conditions	contributing to death b	ributing to death but not resulting in tha undarlying ceusa given in Part I.					23b. Did tobacco use contributs to the				use of death	
requires that the death been signed by the atte should be detached for	by Phy								10	Yss 20	No 3□F	Probably	4 Donknov	
he law requires to has been signed age 2 should be									24a. Was	an autopsy	24b.	Were aut	opsy findings	
	Completed								pen	oinieu :		completic of death?	n of cause	
yelclen: The lav	E O								10	Yes all	No.	1 ☐ Yas	No	
elclan: The certificate lirector, pe	Bec	25. Wes case referred to medical						28. Place of Dee				10,00		
	ToB	examiner?	Hospitel: 1 Dippati	ent 2	EB/Outnation	nt 3□ DOA	Othe	arte	ome 50 kes		Other /Sn	ecity)		
		27. Menner of Deeth		28c. Dete of Injury (Month, Dey Year)  28b. Time of Injury Work?							ow Injury occurred			
Attending r death. ector: After by the fune	atio	Neturel 5 Pending Investigation		(Month, Dey Year)				es 2 □ No						
or Attending after death. Director: After d in by the fune	Certification:	2 Accident 3 Sulcide 4 Homloide    Nestigation   M   1 Yes 2   1							28f. Location (Street and Number or Rural Route Number, City or Town, Stete)					
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29e. Certifier (Check only one) Certifying P	hysician: To the best miner: On the basis o end mannar st	f axamine	owledge, deet otion end/or in	n occurred et t vestigetion, In	the tim	e, dete end plece Inlon, deeth occu	, end dua to the rred et the time,	cause(s) an dete end ple	d manner a ace, end du	as stated. se to the ce	ouse(s)	
o the	Z S	29b. Signature and title of certifiar				29c. L	icense	numbar		29d. Date s	igned (Mon	nth, Day, Y	ear)	
F 3 F 0		> Koull	П.	Me (	Mr	D28	835	2					1997	
		30. Neme and eddress of person who								_				
		Krishan Mathu	c, M.D	P.	O. B	ox 272	29,	La Pla	ata, M	D 20	646			

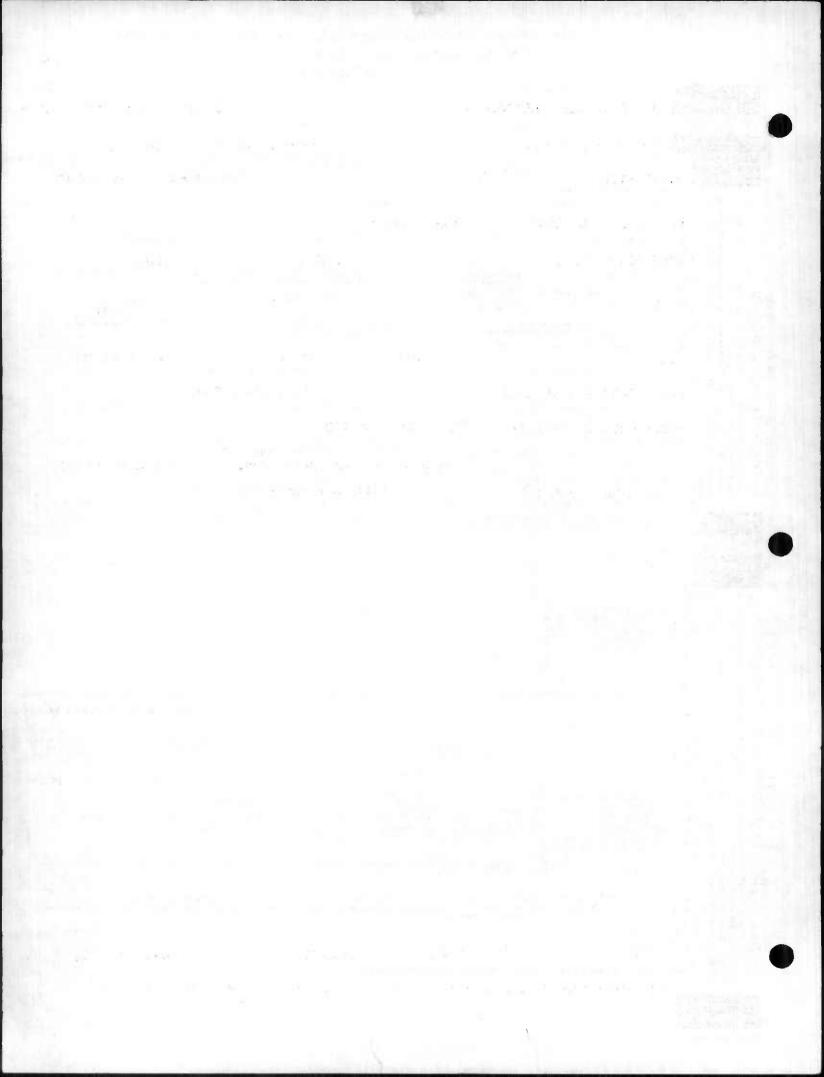
Registrar

State

31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

Jalia Davidson Randall.



Certificate

State of Maryland / Department of

of Health and Mental	Hygiene	C	7	3		6	4	Ls
of Death		4			V			
UI D'Calli	Reg No							

**Physician** /Medical Examiner 1. Decedent's Nema (First, Middle, Last)

Month SEPTEMBER 26

2. Dete of Death

3. Time of Death

10d. inside City Limits

1 ☐ Yas 2 No

4b. City, Town, or Location of Death

1997 8:29AM 4c. County of Death

Funeral

8. Dete of Birth July I,

PRINCE GEORGE'S

10g. Citizen of What Country?

United States

14. Race - American indian.

Bieck, Whita, atc.

Specify. White

16b. Kind of Business/Industry

Military

9. Birthpiece (State or Foreign New York

Director

20

r than "natural", or liente 23a or 28a-f shor the Medical Examiner must be notified at

2 should be f and Mental F marked

ROBERT N. BROWN, SR

Maryland 21215-0020 important: If health a important: If hen 27 is any injury or other traus once. Baltimore,

Physician /Medical Examiner

sician and burial-transit certificate be exec ed by the attending physician detached for use as the buria signed by should I certificate has this funeral ne Hospital or Attending Pl n 24 hours after death. Ne Funeral Director: After ti After t the 3

Box 68760

P.O.

of Vital Records,

Division

Examiner Physician/Medical Ď Completed Be To Certification: Medicai

Robert Nelson Brown, Sr. 4a. Facility Name (If not Institution, give streat and number) CAMP SPRINGS MALCOLM GROW MEDICAL CENTER If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Days **1** M 2□ F 72 202-20-1968 Yrs. Usuai Residence of Decedent 10a Stata 10b County 10c. City, Town or Location Director Prince George's Brandywine Maryland 10e. Street end Number 10f. Zip Code 20613 7520 Earnshaw Drive 12. Was Decedent Ever in U,S. Armed Forces? MXYss 2 □ No 1946— If Yes, Give Yaar or Detes: 1966 Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Nevar Married Married 1□ Yes 2□ No Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation 15. Decedent's Education (Specify only highest grada completed) (Giva kind of work dona during most of working life. DO NOT use ratired) Elementery/Secondery (0-12) 12 College (1-4or 5+) U.S.A. Airforce 18. Mother's Nama (First, Middle, Meiden Surname) 17. Fathar's Nama (First, Middle, Last) Be Ruth Tiffany Walter Brown 19a. Informent's Neme/Reletionship (Type, Print) Gladys Brown 20b. Placa of Disposition (Nema of Sept 30, 1997 cemetery, cremetory or other place) 20a Method of Disposition

AB Burlel 2 Cramation 3 Ramoval from Sleta 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 21. Signature of Funerel Sarvica Licensee Alexandria Ferry Road, Clinton, Maryland 20735 Immediate Cause (Finel diseesa or condition resulting in death) HYPOXEMIA/HYPERCARBIA Due to (or es a consequence of): Sequentielly ilst conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of):

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7520 Earnshaw Drive, Brandywine, Maryland 20613 20c. Location - City or Town, Stete

Cheltenham, Maryland 22. Name and Addrass of Facility Lee Funeral Home, Inc 6633 01d

23a. Part1. Enter the disease, or complications their caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset and Death

UNKNOWN

UNKNOWN

END-STAGE SQUAMOUS CELL LUNG CANCER

Dua to (or as e consequance of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown

RECURRENT PLEURAL EFFUSIONS

24e. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of causa of death?

2 No 1 ☐ Yes 26. Placa of Deeth (Check only one)

1 ☐ Yas 2 No

25. Wes case referred to medical axeminer? 1 ☐ Yas 2 🕱 No

31. Deta filed (Month, Dey, Year) SEP 3 0

Hospitei: 1 K inpatient 28a. Dete of injury (Month, Dey Year) 5 Panding invastigation

2 ER/Outpatient 3 DOA

Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28c. injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29e. Certifier (Check only one)

27. Menner of Death

1 Neturel

2 Accident

4 ☐ Homicide

3 ☐ Sulcide

\*\*Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and mennar as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier 911

6 Could not be determined

29c. Licansa number D43956 MD

29d. Date signed (Month, Dey, Year) SEPTEMBER 26, 1997

28f. Location (Street and Number or Rural Route Number, City or Town, State)

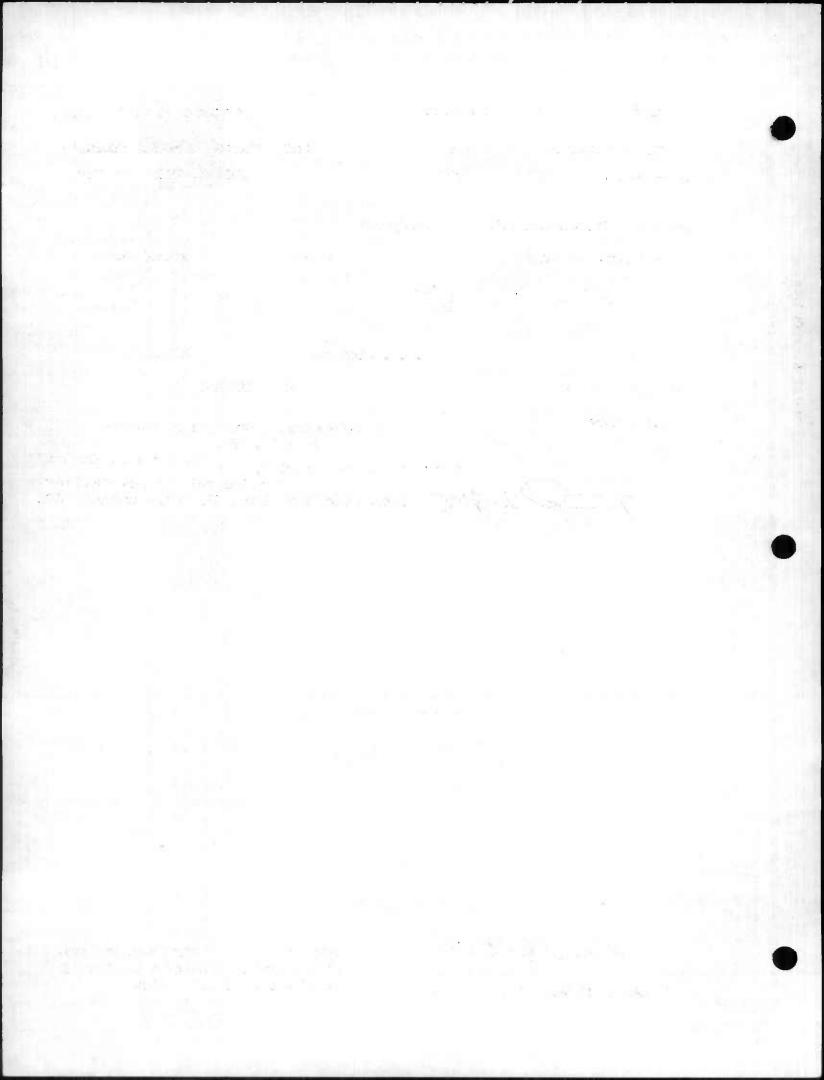
30. Nema end addrass of person who completed cause of deeth (Item 23e) (Type, Print)

89 MDG/1050 W. PERIMETER RD SUITE C1-7

ANDREWS AFB, MD 20762-6600

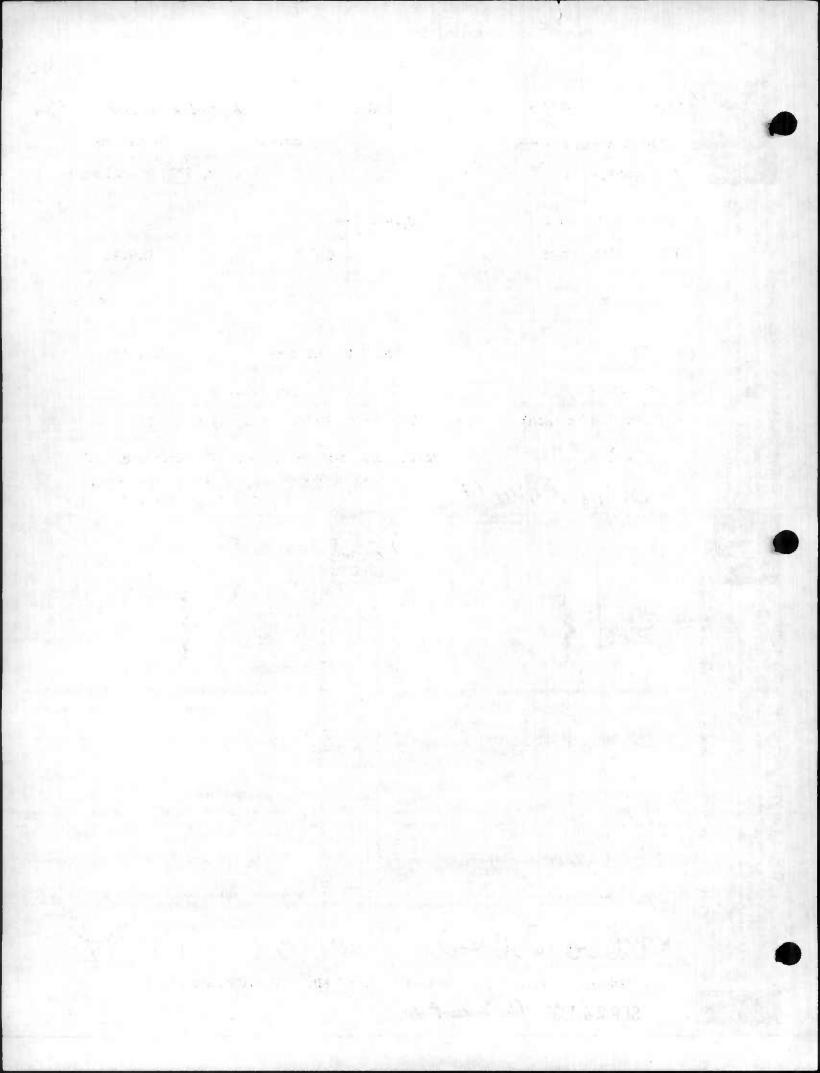
State Registrar WILLIAM A. STINNETTE, MAJ, USAF, MC 32. Registrar's Signatura

To the Vithin 2



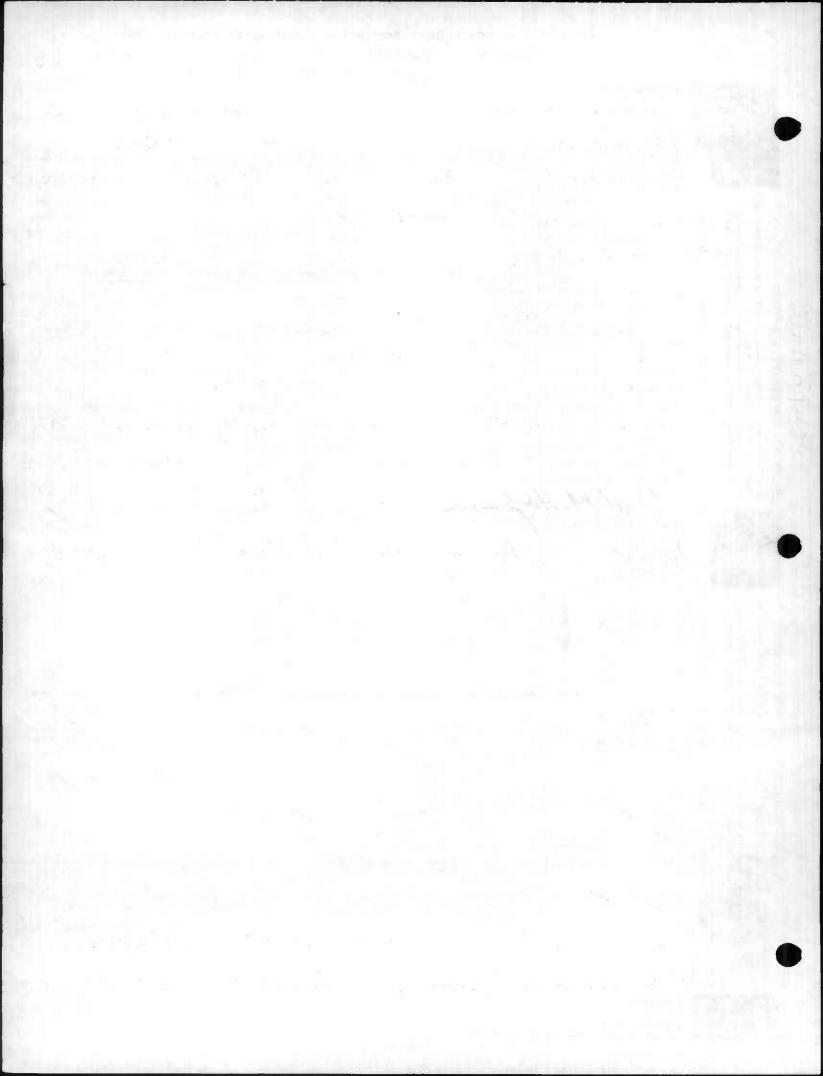
State of Maryland / Department of Health and Mental Hygiene

30645 Certificate of Death 1. Decadant's Nama (First Middle Last) 2. Data of Death **Physician** Month Year 845 LEO BALK hEPTEmber 21, 1997 /Medicai 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Stella Maris Hospice 8. Data of Birth (Month, Day, Year) May 9, 193 5. Social Sacurity Numbar If Under 1 Year If Under 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 9. Birthpleca (Stata or Foraign Country) Oklahoma **Funeral** 10XM 20 F Days 61 Yrs. Director 444-32-8755 Usual Rasidance of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show items 23a or 28a-f ahoviner rount be notified at Director 1 ☐ Yas 2 No Carroll Sykesville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1722 Gemini Drive 21784 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☑ Xyas 2 ☐ No If Yas, Giva Yaar or Datas: 1973 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. traumatic event, tre Medical Examiner filed within 72 hours after 1 □ Navar Marriad 2 □ Marriad 21215-0020 ŏ 1 ☐ Yas 2 ☐XNo þ 3 ☐ Widowed 4 ☑ Divorced Specify White "natural", Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) and Mentel Hygiene. Elementary/Secondery (0-12) Coilega (1-4or 5+) 12 Chief Petty Officer U.S. Navy Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 1 and 2 should be Leo Joseph Balk Fay Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) or other tra Mr. David Balk (Son) 1722 Gemini Drive Sykesville, MD 21784 20a. Mathod of Disposition 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata Carroll Cremation Serv. 9/22/97 injury 4 ☐ Donation 5 ☐ Othar (Spacify) important Hampstead, MD 21. Signature of Funarai Service Licenses 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195) any in Sykesville, MD 21784 (410)-795-1400 23a. Part1. Entar tha disaasa, or complications that a sed tha daath. Do not antar the mode of dying, such as cardiac or respirelory errest shock, or haert fallura. List only ona causa on the lina. Approximate Intervel Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in daath) /Medical **Examiner** Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaesa or Injury that initiated evants rasulting In daath) Last P.O. Box 68760, physician Physician/Medical Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? cate has been signed by pege 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara autopsy findings available prior to completion of causa of daath? Completed 24a. Was an autopsy performed? After this certificate 1 Yes 2 KNO 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: Be 25. Wes casa rafarrad to medical 26. Placa of Daath (Chack only ona) Other: 4 Nursing Homa 5 Rasidance 6 Sother (Specify) HOSPICE 2 1 ☐ Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: 28b. Tima of 28c. Injury at Work? 1 Maturai 5 Pending invastigation death. 1 Yas 2 No 2 Accidant after death in by the 6 Could not be datarminad 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica bullding, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 24 hours af Funeral D letely filled is 1 Dertifying Physician: To the bast of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian Medicai within 2 To the I To the 29b. Signature and titla of certifiar 29c. Licansa numbar 30. Nema and address of person who complated cause of death (Itam 23a) (Type, Print) DR. PENELOPE EDWARDS 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Data filed (Month, Day, Year) 22. Registrar's Signatura State SEP 2 4 1997 Registrar



					State of	f Marylar		artmen			and M	lental Hy		97	30646
	11 -	110	1. Decedent's Nama (F	irst, Middle, Li	ast)	-71						2. Date of Dec			3. Tima of Death
000	Physic /Medi		Joseph	Franc	is Bal	1						Septe	nher	17 C	7:15P
	Exami		4a. Facility Name (If no	t institution, gi	va street and nun	n <i>ber)</i>	1. It		4	b. City, To	wn, or Lo	cation of Death	-	ounty of De	
					1 Hospi	ltal				East				albot	
	Funeral		5. Social Security Number		Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.		if Under Months	1 Yaar Days	If Undar: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Bi	irthplace (State or Foreign Country)
	Director		579-20-6 Usual Rasidence of De	3/3	A	7	4 115.					Dec.14	1,192	22 P	ennsylvani
	Age at			b. County		10c. Cit	ty, Town or Lo	cation							10d. inside City Limits
	the Maryland 28a-f show notified at	tor	Md. Q	ueen A	Anne's	S	teven	svil	le						1 ☐ Yes 2 ☑ No
	ath with the Maryla 23a or 28a-f show ust be notified at	Director	10e. Street and Numbe	r				10f. Zip	Code				10g. Citiza	n of What C	Country?
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50	or Name	y Funeral	11. Marital Status 1 ☐ Nevar Married		Armed For	dent Ever in U rcas? 2 □ No e WWII	l,S. 13.	Was Deced f Yas, spec 1 ☐ Yes			gin? (Spe , Puerto	ecify Yas or No Rican, etc.)		. Raca - Am Biack, Wh	narican Indian, nite, etc. White
3	2 hours shursif, cal Ex	d by	3 Widowed 4		Korea ducation	& Vi	etnam								
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212	the Mark	E O	Elementary/Seconde	ry (0-12)	College (1	-4or 5+)		S. Na					U.	S. N	lavy
	offish of the	Be C	17. Fathar's Name (Firs	t, Middla, Las	)					18. Mothe	r's Name	(First, Middle,	Maiden Su	ımame)	
- a	Wenta Wenta or Manual Min e	ToE	George C	. Ball						Anna	Mc Mc	Cahey			
Maryland	2 sho and is ma		19a. Informant's Name			Wife	19b. Meilir	ng Address	(Street a	and Numbe	er or Rure	I Route Number	r, City or T	Town, Stete,	, Zip Code)
	f Health (Health Item 27 other tr		Mrs. K.		ia Bal						r.,				Md. 21666
Baltimore,	8 = 5		20a. Method of Disposit		Ramovai from 5	State	Place of Dispo cemetery, crer				i	Date			or Town, Stata
量	Department Department Important any Injury		21. Signature of Funera		-	Ga	te of	. Name an	d Addres	s of Facilit	V				pring, Md.
ñ	Ceparti Importa any inj		1/1/	121	1101	/	. 77	7.7	- T	7.6	1	in & 1	lewna	am Fu	neral HOme
			23a. Part1. Enter the d shock, or heart fa	Isease, or con	polications that ca	ausad the deat	h. Do not ent	06 Shar tha mod	namr	ock	Rd.	, Ches	ster,	Md.	21619 Approximate
-	Physician		shock, or heart fa	ilure. List only	one dause on e	ach line.				1					Interval Between Onset and Death
	/Medical	Ш	Immediate Cause (Fina diseese or condition	ıl	A	cute	My	عدد	roli	al z	Inf	Farct	101	7	minutes
	Examiner		resulting in deeth)		ө		or as a consec								
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	ata be axecuted hysician and the burial-transit	Examiner	Sequentially list conditi if any, leading to imme-	ons, diate		Due to (d	or es e conseq	uence of):							
8760,	ata be a hysician the buris	dicai E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.												
687	ficata physical ps the	0	thet initiated events resulting in death) Last	- 1		Due to (o	r as a conseq	uence of):							
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	death e atte	sicia	Part II. Other significan	t conditions	contributing to de	ath but not res	utting in the u	ndertvina c	ause dive	n in Part I		23b. Did 1	obacco us	se contribu	ta to the cause of death?
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S,	ss tha gned be de	by F	Hyper.	tens	LON										
Division of Vital Records, P.O.	Attanding Physician: The law requires that the death certific or death.  ector: After this certificata has been signed by the attanding p by the attanding p by the funeral director, page 2 should be detached for use as	Completed	Obesi	ty								24a. Was perfo	an autopsy med?	/ 24b	. Were autopsy findings available prior to
ec	has be	npje													completion of cause of deeth?
<u>=</u>	The ata h	Co										101	es 2	No	1 ☐ Yes 2 ☑ No
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o	Phys this ral dir	. To	1 ☐ Yes 2 ☐ No 27. Manner of Deeth		1 11	npatient 2	ER/Outpetien			JE NU		ne 5 🗆 Resid			pecify)
o	ding th. After	tion		☐ Pending investigation		f Injury h, Day Year)	Injury	м	8c. Injury Work	:?` ′es 2 □ !		Edd. Describe i	iow injury (	ACCUIT 60	
/ISI	Attan r deal ector: by tha	Certification:	3 ☐ Suicide 6	Could not be	28e. Placa	of Injury - At h	ome, farm, str					28f. Location (S	Street and I	Number or I	Rural Route Number,
Ö	s afte	Cert	4 Homicide		buildin	ig, etc. (Specif	(y)					City or Tov	vn, Stete)		
	To the Hospital or Attanding Physician: The I within 24 hours after death.  To the Funeral Director: After this certificata ha completely filled in by tha funeral director, page		(Check only 2	Certifying Pl Madical Exa	nysician: To the l	sls of examina	wledge, death	occurred a	at tha tim	a, date and	d placa, a	and due to the	cause(s) ar	nd manner a laca, and di	as stated. ue to the cause(s)
	thin of the	Medical	one) 29b. Signature and titla	of certifier	and mann	er stated.		290	License	number			29d. Data	signed (Mor	nth, Day, Year)
	F 3 F 8		A.	Look	Now	NI		1			5		091	18/0	27
			30. Neme and address	of person ut-	completed com	of deeth (tt-	n 22a) /T.m-	Print)	-				- "	101	/
			606 Du	tche	A A Z	or deepth (item	11 230) (1ype,	3 0 0	6	Eas	to	2	MA	24	501
	Sta	te	31. Dete filed (Month, D	lay, Year)		egistrar's Signa		2.10			_ , _	. /			
	Registr	_	SE.	Y 191	997	Julia Dav	idson Ra	ndelle							

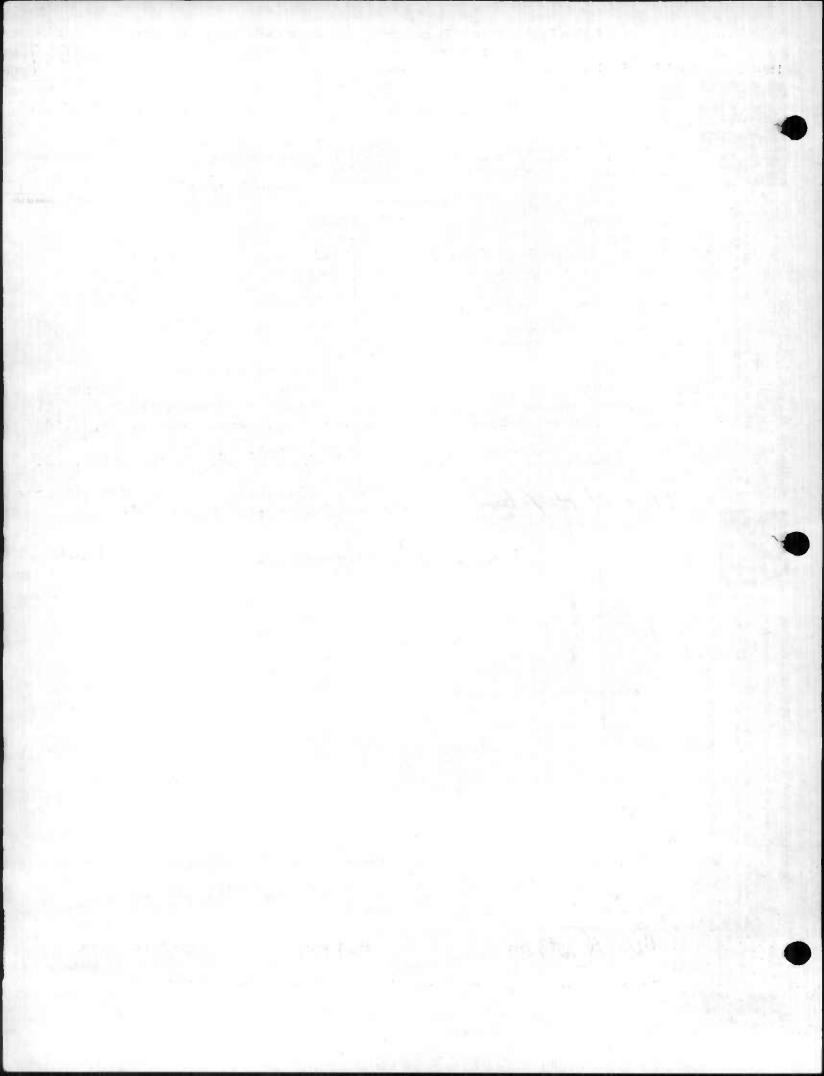
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		1 Description At	- /Flore 4 ** * **	tan				ificate of	Dodan	10-: :-	Reg. No.		1
ıysiclan Medical		1. Decedant's Nam.	215			2600	N			2. Data of D Month SEP	Day	Year 997	3. Tima of D
kaminer	ľ	4a. Facility Nama (/				)			4b. City, Town, or			ty of Death	
	4	Univ. o		HOS 6. Sex		ga (In yrs. last	hirthday)	If Under 1 Year	Baltin # Under 24 Hrs			timor	
neral ector		215-10-1	1394	1 M	OFT F	79		Months Days		(Month, E	ay, Year) 31,191		place (Stata or I ntry) aryland
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190	3	10e. Street and Nur	mbar			1		10f. Zip Coda			10g. Citizen o	What Cou	ntry?
G	-	3004 Nor	rth Ri	dge 1	Road .	Apt. 3	321	210	143		U.S.	Α.	
by Funeral Director		11. Maritai Status 1  Nevar Merri 3  Nidowed		ied 1	Vas Decedant irmad Forcas' Yas 2 Yas, Giva Yas, Giva	?	lf Y	es Decedent of l Yas, specify Cub	Hispanic Origin? ( ban, Maxican, Pue Specify:	Specify Yas or N to Rica <i>n</i> , etc.)	Bi	ica - Amaricack, White,	atc.
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DHMH 16 Rav 6/95



						Death		Mental Hy	Reg. No.	97	30648
1. Decedent's Nama (First, Middla, La Helen		ownsend		Burg	gess			2. Data of Do Month Septem	Day	Yaar 1997	3. Tima of Death
4a. Facility Nama (If not institution, giv	ra straat and number)				4	b. City, To	own, or Lo	ocation of Dea		y of Death	
The Kent and Queer	Anne's Ho	ospital				Ches	tert	cown	Ke	nt	
5. Social Sacurity Number 6. S		(In yrs. last b	1	If Undar	1 Yaar Days	If Undar Hours	24 Hrs. Min.	8. Data of Bi	rth av. Yaarl	9. Birth	placa (Stata or Forai
	I□M XTXF	60	Yrs.					Feb. 2	22,1937	Rocl	KHall, MD
Usual Rasidanca of Decadant  10a. Stata 10b. County		10c. City, Tov	wn or Loca	tion							40d Incide City I in 1
MD Queen A	Anne's	Cent									10d. Insida City Limi 1 XYas 2 □ N
10a. Streat and Number 724 Murphy Roa	ad			10f. Zip	Coda 617				U.S.A.		untry?
11. Marital Status	12. Was Decedant E Armed Forcas?	evar in U,S.	13. Wa	s Deced	ant of H	ispanic Ori	igin? (Sp	ecify Yas or N Rican, atc.)	o- 14. Ra		ican Indian,
1 □ Navar Married 2 □ Marriad	1 ☐ Yas 2 ☒ N If Yas, Give Yaar or Datas:	lo			X No	Specify:		riodii, ato.,		white	
15. Decedant's Ed (Spacify only highast gra	ducation	168	. Decedar	t's Usua	Occup	ation	t of work	ina	16b. Kind of I	Businass/I	ndustry
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12	4	N	lurse	an	d S	ecre	tar	У	House	of !	Burgess
17. Father's Nema (First, Middle, Last)									, Meidan Suma		
Robert Edward	Townsend	d Sr.				Sara	Et	hel Le	eCompte	9	
19e. Informant's Name/Ralationship (	Type, Print)								er, City or Town		
Bruce Burgess	-Son	7	24 M	lurp	hy	Rd.,	Ce	ntrev	ille, 1	1d.	21617
20a. Method of Disposition  1 🔁 Burial 2 □ Cramation 3 □  4 □ Donation 5 □ Other (Specific		20b. Plece of cemate Wesle				a) emet	eSe	pt.9,	20c. Location 1997 <sub>ROC</sub>	-City or T	own, Stata all, Md.
21. Signature of Gunaral Sarvice Licago	2016		23 N €	ame and	Addre	uHer	ya Fe	llows Home,	Helfer P.A.	nbei	n& MD 21617
23a. Part1. Entar tha disaasa, or compshock, or heert fallura. List only	olication that caused ona cause on each lin	tha daath. Do					_				Approximate Interval Batween Onset and Daeth
Immediata Causa (Final disaasa or condition resulting in daath)		A CON		-	Hon	ncyn	1340	15			6 Hens
Sequantially list conditions, if any, leading to immediate cause. Enter Underlying	b. —	Dua to (or as a	consequa	nca of):							
causa. Entar Undarlying Ceuse (Disaasa or Injury that initiatad events rasulting In daath) Last	c	Dua to (or as a	consaquar	nce of):		-					
C	d										
Part II. Other significant conditions or	ontributing to death bu	t not resulting I	in tha unda	rrlying ca	usa giva	an in Part I		23b. Dld	tobacco usa c	ontribute t	to the cause of death
								10	Yes 20 No	3□ Pro	obably 4 Unknow
									s an autopsy ormed?	a	/ara autopsy findings vailabla prior to ompletion of causa i deeth?
								10	Yas 2 No	1	□Yas 2□No
25. Was casa rafarrad to medicat						26. Place	of Deat	h (Check only	-,1		
axaminar? 1 ☐ Yas 2 <b>X</b> Î No	Hospital:	at 2 ER/O	utpatient	3 DO/	Othe	ar:			idanca 6 □Ot	her /Snec	(fv)
27. Mennar of Daath  12 Natural 5 Panding  2 Accidant invastigation	28a. Date of Injun (Month, Day	28b.	Tima of Injury		c. Injury Work	at			how injury occu		,,
Z LI AUCIDATIL							-	28f. Location /	Street and Num	ber or Rur	
3 ☐ Suicida 6 ☐ Could not be datarmined	28a. Place of Inju- building, atc.	ry - At noma, is (Spacify)	arm, streat	, ractory,	Offica				wn, Stata)	00, 0, 1,0,	al Routa Number,

State Registrar

**Physicia** /Medic Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mayrand Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "ratural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarient ment be rutified at abotes. Spices.

Physician /Medical Examiner

To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

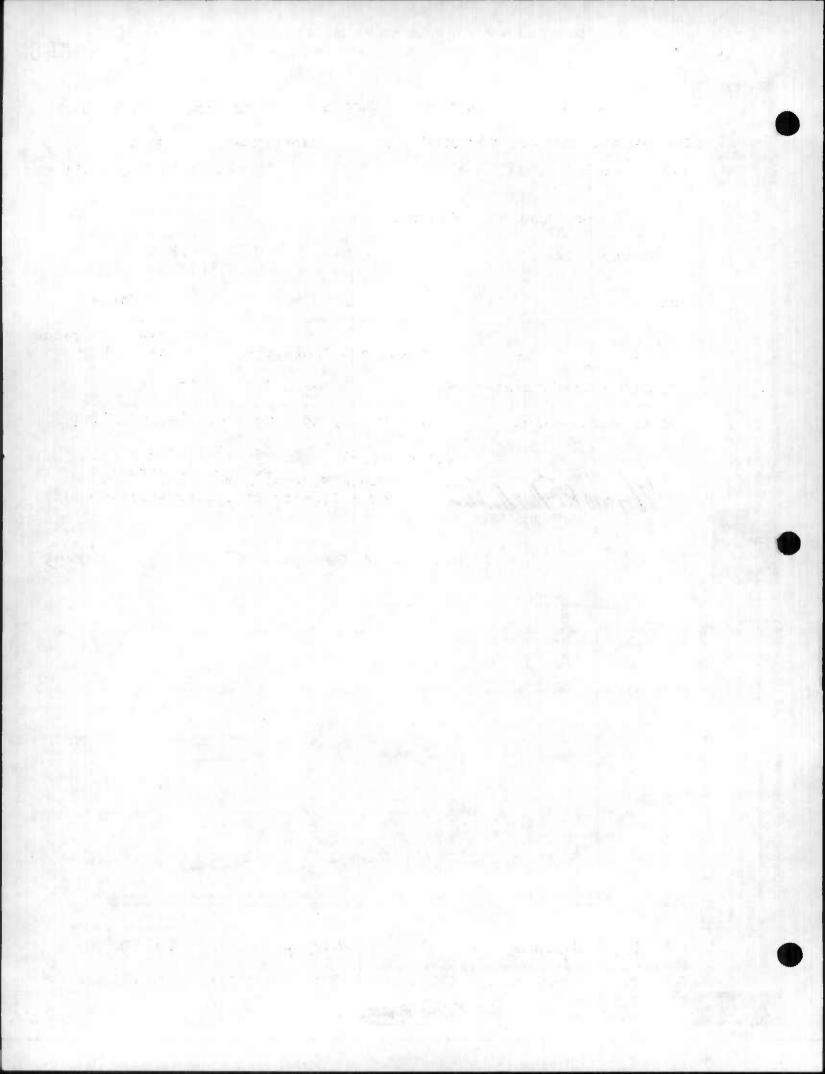
31. Date filed (Month, Day, Yeer) SEP 8

30. Nama and eddrass of parson the complated cause of death (item 23e) (Type, Print)

John C. Seymour, M.D.; 122 Speer Road; Chestertown, Md. 21620 32. Registrar's Signetura

17-13824

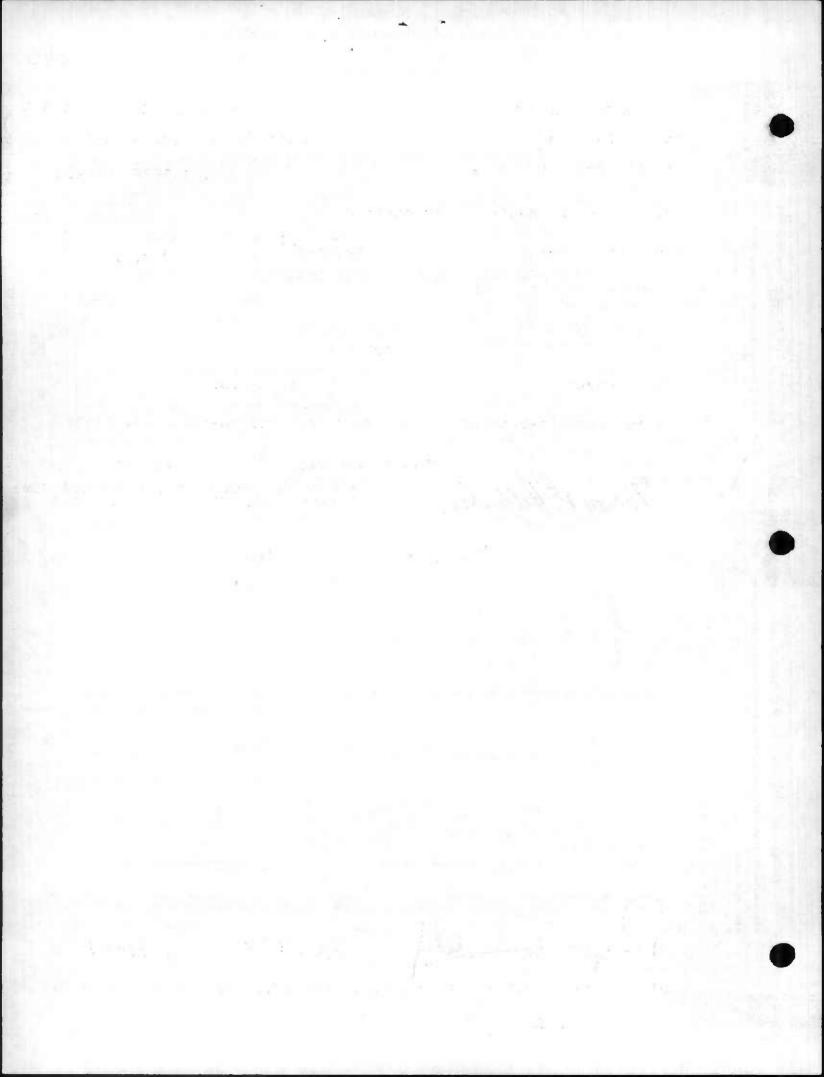
DHMH 16 Rev 6/95



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3061.9

			•	Cer	tificate of	Death	Re	g. No.	,	00045
Physicia	'n	1. Decedent's Neme (First, Middle, La	st)			2	2. Dete of Deeth Month	Dey	Year	3. Time of Death
/Medic		WILSON BENN					Aug.30	1997		12:35 AM
Examin	er	4e. Fecility Neme (If not institution, git 4405 Main Stre				4b. City, Town, or Local Grasonvi		4c. County Queer		0.10
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs	. last birthdey)	If Under 1 Year Months Devs		B. Dete of Birth (Month, Dey,			ace (State or Foreign
Director			12 M 2□ F 68	Yrs.	Wiotilia Days	Trouis Will.	Dec.31	,1928	3 Ma	ryland
how		Usuel Residence of Decedent  10a. Stete 10b. County  Md. Queen		ity, Town or Loc					10	d. Inside City Limits
M P P	cto	Md. Queen	Allie 5 G	Lasonv	TITE					1 ☐ Yes 2 ☒ No
oeath with the Meryland	Funeral Director	10e. Street end Number 4405 Main Stre	et		10f. Zip Code	21638	10	g. Citizen of V		ry?
	ner	11. Meritel Status	12. Wes Decedent Ever In U	J,S. 13. V	Ves Decedent of I	Hispenic Origin? (Speci pan, Mexican, Puerto Ri	fy Yes or No-	14. Rec	e - America	
0 0 0	þ	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No if Yes, Give Yeer or Detes:		☐ Yes 2 No		can, etc.)	Specify	ck, White, e	ite
"natural",	Completed	15. Decedent's E (Specify only highest gr		16a. Deced	ent's Usuel Occup	pation during most of working	10	Sb. Kind of Bu	usiness/Indu	ustry
then.	dmo	Elementery/Secondery (0-12)	College (1-4or 5+)		o NOT use retire	ed)				
al Hygi Jother Vent, I	Be	17. Father's Neme (First, Middle, Last	)			18. Mother's Neme (		alden Surnam	10)	
Ment arked	2	Otho Bennett				Roxie				
la m		19e. tnforment's Neme/Reletionship				t end Number or Rural I				
Health om 27 ther t		Carlton Bennet				St., Gras		oc. Location -		
8 = 2°		→ Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specie	Leitional Itolii 2006		sition (Neme of setory or other pla	sepu.	1,1997			
injury	1	21. Signetyre of Futheral Service Lice	DO	22.	Cemet	ess of Fecility		Oak I		
Depart I		17/1 may V	Holland.	F (	ellows,	Helfenber	in & No	ewnam	Fune	eral HOme
		23e, Pert1. Enter the discount or com- shock, or heart feilure. List only	plications that caused the deb	th. Do not ente	or the mode of dyi	ing, such es cardiec or	respiratory arres	it,		Approximete Interval Between
hysician					0	1.				Onset and Death
Medical xaminer		Immediate Cause (Finel disease or condition resulting in deeth)	· Corci	nom	a 01	lune	2			3 mm -
1000	ē	resulting in deathy	Due to (	or es a consequ	uence of):		0		i	
ansit	Examiner	Sequentially list conditions	b. Due to (	or as a consequ	ience of):		-		<u> </u>	
		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			es e consequence of):					
physic the b	Medicai	that initieted events resulting in deeth) Last	Due to (	or es e consequ	ence of):					
0 0			d							
igned by the attendir be detached for use	Physician/	Pert II. Other significant conditions of	ontributing to death but not res	sulting in the un	derlying cause gi	iven in Pert I.	23b. Did tob	acco usa cor	ntribute to 1	the cause of death?
by the	Phy						1 [Q*Yet	2 □ No	3 Probe	ably 4 Unknown
	ক্র									
been si should	Completed						24a. Wes an performe		avai	re eutopsy findings liebie prior to apletion of cause
8 CI	d L						_0.0	i i	of de	eath?
		OF Management to market					1 ☐ Yes		10	Yes 2□ No
irecto	o Be	25. Wes case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospitel:	) = D (O	Ott	26. Piece of Deeth (	**			
	7: To	27. Menner of Death		ER/Outpatient 28b. Time of	3LI DON	4   Nursing Home				
ctor: Afte	Description   Description				rk? ]Yes 2□No	28d. Describe how injury occurred				
Director S in by t	ertific	3 Suicide 4 Homicide  6 Could not be determined  28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)					f. Location (Stre City or Town,	et end Numb Stete)	er or Rural	Route Number,
	edical C	29a. Cadilles 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examine end menner steted.	owledge, deeth	occurred at the tile	ime, dete end piece, an opinion, deeth occurred	d due to the cau et the time, det	se(s) and ma	nner es sta and due to t	ited. the cause(s)
vithin compl		29b. Signature and title of certifier	0.0000		29c. Licens	se number	290	d. Dete signe	d (Month, D	ay, Year)
7,-0		M Contract	2 h	ly	2	05754		8.3	1-9-	7
		30. Neme and address of person who	completed cause of deeth (Itel	Type, F	Print)	(		0	1	
		Ralph E. Libb	V.M.D.: 204	Medica	al Cent	er Rd.,G	casonv	ille.	Md.	21638
Stat	٠	31. Dete filed (Month, Dey, Year)	32. Registrer's Sign	eture					F	
Registra	r	SEP 8	997 I Julia Va	udson-16	ndelle					
1 40 D 0000			The second second							



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 30650 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 0815 0 997 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street for 4c. County of Deeth County Acoptal 6. Sex (7. Age (in yrs. lest birthday)) 9. Birthblace (State of If Under 1 Year 8. Date of Birth (Month, Day, 1□M 2 F Months Days Hours Min. 23 1900 Frank. Co, fo Yrs. of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Vashington 1 ☐ Yes 2 KNo Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever In U.S. Armed Forces? 1 | Yes 2 | No | Yes, Give 20409 er 21742 USA 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1□ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) romemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Schaet ictor 19b. Meiling Address (Street and Number Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Hagerstown aul 21740 20b. Pleca of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Hill Cemetery 10 oseytown 22. Name and Address of Facility Miller 21. Signature of Funeral Service Licensee Funeral Grove Anter the disease, or cofiplications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory errest, heart failure. List only one cause on each line. Greencystle Pa 17225 Approximate Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) XMS Due (or es e consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Ihat Initiated events resulting in death) Last to (or as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 □ Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 🗆 Yes 22 No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Nems 23a or 28a-f

6

is marked other

important: If Item 27 is any injury or other trax once.

Health and Mental

90

Baltimore, Maryland 21215-0020

3

the Medical Examiner must be notified

Director

Funeral

þ

Be Completed

2

The law requires that the death certificate be axecuted

bordell, Hazel

Physician/Medical Examiner burial-trans attanding physiclan for usa as the buria S been signed by I should be detact by Completed has certificate Be Certification: To this Director: After this To the Hospital of within 24 hours of To the Funeral Complately filled

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death Neturel 5 Pending investigation 2 Accident

3 Suicide 4 Homicide

6 Could not be determined

28a. Dete of Injury (Month, Day Year) 28b. Time of

Hospital: Inpatient

28c. Injury et Work? Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Rd

26. Plece of Death (Check only one)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a, Certifier 29b. Signeture and title of cartifier

Tertifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

cal

29c. License number

Campus

30. Name and address of person who completed crust of death (Item 23a) (Type, Print)

Dr. M. Riggle
31. Date filed (Month, Day, Year)

01

11110 32. Registrar's Signature relia Davidson

State Registrar

edical

**DHMH 16 Ray 6/95** 

death.

ŏ

29d. Date signed (Month, Dey, Year)

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

30651

	Decedent'a Nama (First, Middle	e, Last)	D 9			2. Date of De		3. Time of	
ysician Aedical	PAUL	HEI	NRY	CATLET	T	SEPTE	MBER 22	2,1997 16	:39p
aminer	4a. Facility Nama (If not institution	n, giva street and number)			4b. City, Town,	or Location of Deaf	4c. County	of Death	
	Calvert Memori					Frederick			
eral ctor	5. Social Security Number 579 05 5514	6. Sex 7. Ag	ge (In yrs. last birth	day) If Undar 1 Y Months Do		lin. 8. Date of Bir (Month, De Aug. 29	y, Year) 1921	9. Birthplace (State or Country) Wash., D.C.	r Foreign
105	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside Cit	
to to	Maryland Calv	ert	North	Beach				1XI Yes	2 No
Director	10e. Street and Number			10f. Zip Coo			10g. Citizen of V	Vhat Counfry?	
d le	9117 Dayton	Avenue			20714		U	SA	
traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	3 ₩ Widowed 4 Divorced	If Yes Give	No	13. Was Decedant If Yes, specify 0  1 ☐ Yes 2X		(Specify Yes or No larto Ricen, atc.)	- 14. Race Blace Specify	e - Amarican Indian, ck, Whita, atc. " white	
Completed	15. Decedent (Specify only highes	t's Education	168. [	Decedent's Usual Or	ccupation	wadina	16b. Kind of Bu	isiness/industry	
nple	Elementary/Secondary (0-12)	College (1-4or	5+)		one during most of streed)	working			
F S	12 17. Father's Nama (First, Middle,	( not)	but	cher	40 Mashada N	James (Fires Adiable		ervices	
To Be	Joseph			tlett	Ellen			Williams	
trant	19a. informant's Name/Relations  John E. Catlett					Aural Route Number exandria,		Stete, Zip Code) 315	
other	20a. Method of Disposition	7 5011	20b. Place of [	Disposition (Neme o	1	Dete		City or Town, State	
5	1 N Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)			cremetory or other Hill Ceme		9-26-97	Suitla	and, MD	
in ury	21. Signature of Funaral Service		33333	22. Name and A	ddress of Facility			-	
e da	1 William	& Tren		9225 M+		Rausch Fu			
	23a. Part1. Enter the diseasa, or shock, or heart failure. List	complications that cause		0323 ML	• nathony	Lila WI	nus, mu	20736	
_			d the daath. Do no					Approximate	
ian	Silver, Silver Idialo. Elej	only ona causa on each i	d the death. Do no ine.					Approximate Interval Betw Onset and D	veen
cai	Immediate Cause (Final disease or condition			t enter the mode of	dying, such as card	fiac or respiratory a		Interval Betw Onset and D	veen leath
cai ner	Immediate Cause (Final	a. MYOC	Due to (or as e co	enter the mode of	dying, such as card	fiac or respiratory a		Interval Betw Onset and D	veen leath
cai ner je	Immediate Cause (Final disease or condition resulting In death)	a. MYOC	ARDIAN Due to (or as e co	Tw FA insequence of):	dying, such as card	fiac or respiratory a		Interval Betw	veen leath
er e	Immediate Cause (Final disease or condition resulting In death)	a. MYOC	Due to (or as e co	Tw FA insequence of):	dying, such as card	fiac or respiratory a		Interval Betw Onset and D	veen leath
ier Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	a. MYOC	Due to (or as a co	The first the mode of the first the mode of the first th	dying, such as card	fiac or respiratory a		Interval Betw Onset and D	veen leath
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iched for use as the bunal-fransfr	Immediate Cause (Final disease or condition resulting In death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. MYOC  b. CORDAN  c.  d.	Due to (or as a co	Tw FA insequence of): insequence of): insequence of): insequence of): insequence of):	dying, such as card	23b, Did	lobacco use cor	Interval Betwonset and D	reen leath  Es
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व हैं eted by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	a. MYOC  b. CORDAN  c.  d.  ms contributing to death b.	Due to (or as a co	Two FA insequence of):  Insequence of):	dying, such as card	23b, Did	tobacco use cor Yes 2UM6 an autopsy	Interval Betwonset and D  An (NUT)  The Number of the cause of the cau	of death?  Junknown  Indings
Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant condition  CONCEST INF  25. Was case referred to medical examiner?	a. MYOC  b. CORONI  c.  d.  ms contributing to death b  TRIAL F	Due to (or as a co	Two FA insequence of):  insequence of):	dying, such as card  PCTION  as given in Part I.  PTINI  26. Piece of I.	23b. Did 1  24a. Was perfe	tobacco use cor Yes 2 146 an autopsy med?	Interval Betwonset and D  An I N VT  The I	of death?  Junknown  Indings
To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant condition  CONCEST INF  25. Was case referred to medical examiner?  1 Yes 2 2 M6	a. MYOC  b. CORONI  c.  d.  THART  F  TRIAL  Hospital: 1   Inpatie	Due to (or as a co	The FA Insequence of):  Insequence of):	dying, such as card  ARCTION  ASE  a given in Part I.  CT-VION  26. Piece of I.  Other: 4   Nursing	23b. Did 1 24a. Was perfo	tobacco use cor Yes 2 No an autopsy med?	Interval Betwonset and D  An INUT  Y FN2;  Intributa to the cause of a variable prior to completion of ce of death?  1 Yes 2 if a variable prior to completion of ce of death?	of death?  Junknown  Indings
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a properties of the control of the c	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last  Part II. Other significant condition  CONCEST (VE)  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Naturel 5 Pendin investig Suicide 6 Could referred to Medical exercises of Could referred to Me	a. MYOC  b. CORDAN  c	Due to (or as a condition of my knowledge, of examination and/	tenter the mode of  The FA Insequence of):  The Property of the underlying cause  The Underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the underlying cause  The Property of the Underlying cause  The	dying, such as card  PCTON  a given in Part I.  26. Piece of I.  Other: 4   Nursing Injury at Work? 1   Yes 2   No ice  e time, date and piece	23b. Did 1 24a. Was perfo 1 29 Resident of the Control of the Cont	Robacco use cor Yes 2 1 No an autopsy rmed? Yes 2 1 No one) dence 8 1 Oth- now injury occurr Street and Numb vn, State)	Interval Betwoonset and D  An I N V T  Y F N C J  Antributa to the cause of 3 Probably 4 L  24b. Were autopsy fit available prior to completion of cof death?  1 Yes 2 L  er (Specify)  red  er or Rural Route Numb	of death?  If death?  Juknown  Indings  Dusa  No
pletery filled in by the funeral director, page 2 should be detached for use as the burist-transit and before the control of t	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last  Part II. Other significant condition  CONCEST (VE  25. Was case referred to medical examiner?  1 yes 2 Mo  27. Manner of Death 1 Maturel 5 Pending investig 3 Suicide 6 Could determined to the condition of the could be conditioned to the condition of the could be conditioned to the condition of the could be conditioned to the condition of the co	a. MYOC  b. CORDAN  c	Due to (or as a condition of my knowledge, of examination and/	tenter the mode of the insequence of):  The property of the underlying cause o	a givan in Part I.  26. Piece of I.  Other: 4   Nursin: Injury at Work? 1   Yes 2   No ice  te time, date and ple iny opinion, death or	23b. Did 1 24a. Was perfo  24a. Was perfo  24a. Was perfo  25 Deeth (Check only of the course of the time, the course of the time, the course of the time, the course of the time, the course of the course of the course of the time, the course of the cours	Alobacco use core Yes 2 No an autopsy rmed? Yes 2 No one) Idence 8 Other how injury occurr Street and Numb vn, State) cause(s) end ma date and place, if	Interval Betwoonset and D  An I NUT  The Intributa to the cause of the cause of the cause of the cause of the cause of the completion of ce of death?  I Yes 2 I were autopsy fit available prior to completion of ce of death?  I Yes 2 I were or Rural Route Number or Rural Route Route Number or Rural Route R	f death?  If death?  Unknown  Indings  Dusa  No

SEP 26 1997 Studies Reselle

DHMH 16 Rav 6/95

State Registrar

31. Date find (Month, Dey, Year)

97-5332-035 AM **JAMES** 

### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

1745 P

10d. Inside City Limits

21619

Onsat and Death

1 Yes 2000

COCKEREL Certificate of Death t. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** JAMES RICHARD COCKEREL SEPTEMBER 16, 1997 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 105 BAYSIDE DR. (Harbour Sound Chester OUEEN ANNE'S Court) 7. Age (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 6 Sex Birthpleca (Stata or Foreign Country) **Funeral** 1€XM 2□ F Months Deys Hours 404-88-9750 40 Director Kentucky Jan. 26, 1957 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show Queen Anne's be nuffied Md. Chester Director 10e. Street end Numbar 10f. Zip Coda 10g. Citizen of Whet Country? ŏ 105 Bayside Dr. (Harbour Sound Court) U.S.A. Herns 23a death 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispenic Origin? (Spacify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married ò 21215-0020 White 1 Yes 2 No Specify: by 3 Widowed 4 X Wivorcad 'natural'. Completed Medical 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry than Elementery/Secondery (0-12) Collage (1-4or 5+) U.S. Airways Hygiene. Die 12 Flight Attendant marked other Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middla, Maiden Surneme) h end Mental F is marked ou family 2 should I James Amos Cockerel Hilda Kress 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Important If Item 27 is any injury or other tra once. Debra Botkins (Sister) 16303 Norwood Dr.; Tampa, Fl. Baltimore, Sept. Date 18, 1997 20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) Chesapeake Cremation Center Stevensville, Md. Funerai Servica Licensee Fellows, Helfenbein & Newnam Funeral Home rent. Entar tha disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiec or respiretory errest, hock, or heart feilure. List only one causa on each line. Physician /Medical Immediate Cause (Final Chast wound disease or condition resulting in death) Examiner Dua to (or es e consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Diseese or Injury that initieted evants resulting in death) Lest pue Due to (or es e consequence of) buriel Box 68760. physician 90 Due to (or as a consequence of):

Physician/Medical by Completed Be 10 Certification:

use

ed by the detached

signed by

page 2

al or Attending Physician: T s efter deeth. ii Director: After this certifical ad in by the funeral director, p

To the Hospital or within 24 hours aft To the Funeral DI completely filled in

0

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Records,

of Vital

Division

Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Wara autopsy findings available prior to 24a. Wes en eutopsy performed? completion of causa of deeth? 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Daath (Check only ona) 12 Ves 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Thesidenca 6 Other (Specify) 28e. Dete of Injury (28b. Time of 27. Menner of Death 28d. Dascribe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending Subject 9-16-97 17-45 M 1 TYes 2 PNo Self 2 Accident invastigation Shet

6 Could not be datemined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, atc. (Spacify) 4 | Homleide Residence

Buyside 105 Ur.

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

SEPTEMBER 17,1997

1 Cartifying Phyaicien: To the best of my knowledga, daath occurred at the time, data end plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data end plece, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signeture end title of contifier 29c. License number 29d. Dete signed (Month, Dey, Year)

30. Neme end eddrass of parson who complated causa of daeth (Itam 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

OCME

State Registrar

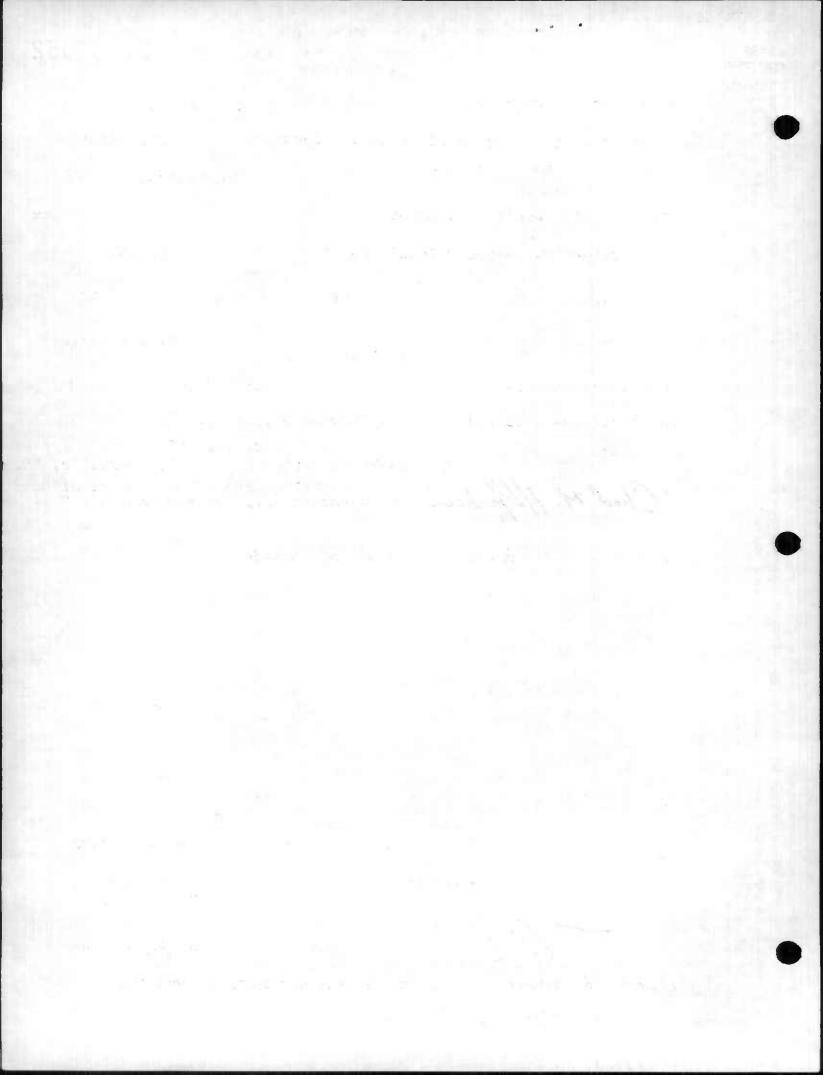
Medical

Jana

31. Dete filed (Month, Day, Year)

SEP 19

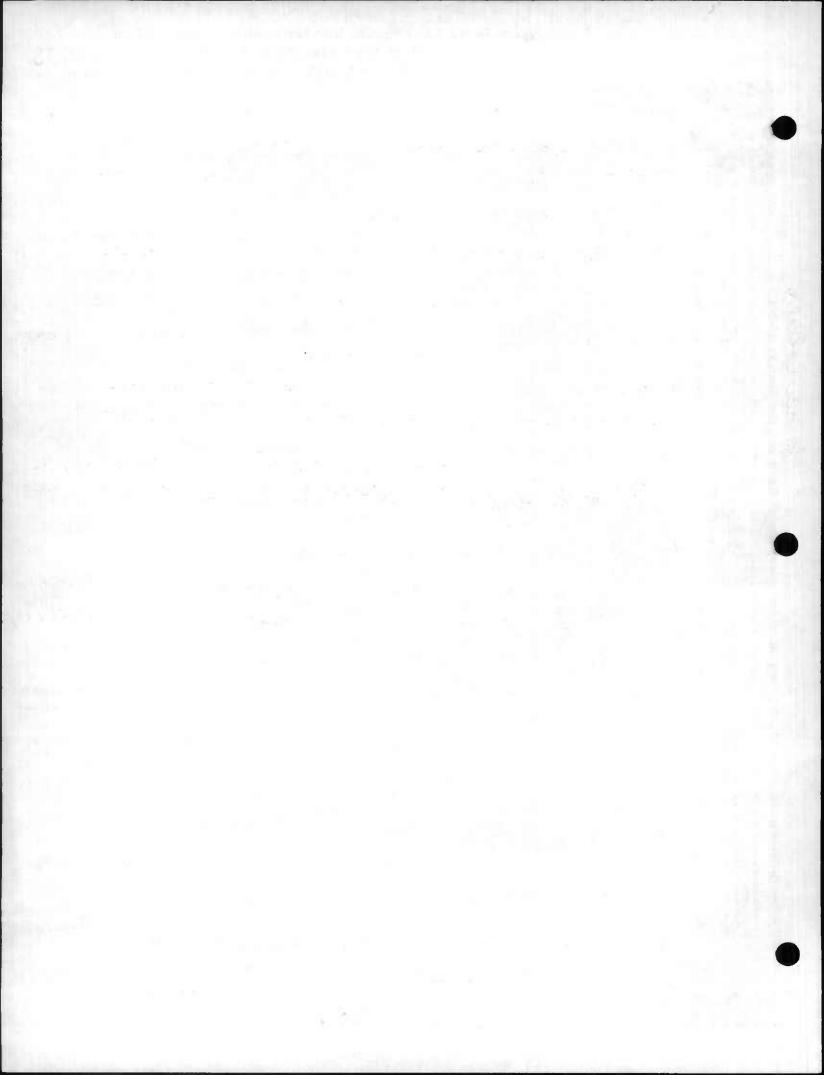
ruler 32. Ragistrar's Signature Julia Davidson



### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

		1. Decedent'a Name (First, Middle, L	ast)				Death	2. Date of De			Time of Death		
Physicia		JAMES ORION C	OLLTER					Month	Day	Year	2.15 DW		
/Medic Examin		4a. Facility Nama (If not institution, gi					4b. City, Town, or	Septen Location of Deat	4c. County		3:15 PM		
Funeral Director		5. Social Security Number 6. 218-12-9338	NFIM 2□E	Easton yrs. last birthday) 81 Yrs.	If Undar Months		East If Undar 24 Hrs Hours Min.	8. Data of Bir (Month, Da	th	Talbo  9. Birthplaca Country) Mary	(Stata or Foreign		
h the Maryland r 28a-f show Incitified at	or	Usual Residence of Dacedent  10a. State 10b. County  Md . Queen	Anne's	City, Town or Lo		1					nside City Limits		
n with the Marytar Se or 28a-f show at be notified at	al Director	10e. Street and Number 101 Sportsman			10f. Zip		8		10g. Citizen of V		- I to AR		
af, or items 2 Examiner mu	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Nidowed 4 Divorced	12. Was Decedent Ever i Armed Forces? ★ Yes 2 No if Yes, Give Yaar or Dates: WW	. 1	Vas Deced Yas, spec		Hispanic Origin? (Span, Maxican, Puer Specify:	specify Yas or No to Rican, etc.)	- 14. Rac Blac Specify	ce - American frock, White, etc.			
were record are then "neture", or the the Medical Exercise	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)				pation during most of wo	rking	16b. Kind of B		y rernment		
Mental Hygi rked other life event, I	To Be Co	17. Fathar's Name (First, Middla, Las Joseph Henry	Construction										
or trauma or trauma		19a. tnformant's Name/Relationship Franklin Smi	(Type, Print) ch-Nephew				t and Number or Ri 2; Quee				le)		
ment of the uny or oth		20a. Method of Disposition  Surial 2 □ Cremation 3 [  4 □ Donation 5 □ Other (Special Content of the Content o	Ramovai from State		natory or or	ther pla	Sept.		97 Falls				
Departition of the control of the co		21. Signature of Fusieral Sarvice Lice	2/0/0	22	. Nama and	d Addra	ass of Facility Ielfenbe Irock Ro						
hysician		23a. Part1. Enter the diseasa, or con shock, or heart failure. List only		leath. Do not ente	er the mode	e of dyi	ing, such as cardia	c or raspiratory a	rrast,	Apr Inta On:	oroximata rval Betwaen set end Death		
/Medical Examiner	J. 6	Immediate Cause (Final disease or condition resulting in death)		o (or as a conseq	uence of):			/			-6-97		
physician end sthe buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Onkrish  Due to	o (or as a consequence of the consequence)	uenca of):	0	inforce	+100		1	- 6-97		
0 0	8	Cause (Disease or Injury that initiated events resulting in death) Last	0.	o (or as a consequ	uence of):								
s been signed by the ettendin 2 should be deteched for use	Physician/M	Part II. Other algnificant conditions									cause of death?		
en signed b	þ							24a. Was	Yes 2□ No an autopsy	24b. Wera a	utopsy findings		
Attending Prysician: The law requires ther the death cerscreect of creeth.  screer. After this certificate has been signed by the ettendin by the funeral director, page 2 should be deteched for use	Completed	(						1 🗆 1	À.,	comple of deat	tion of causa h?		
rsician: In	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 1 Inpatient	2 ☐ ER/Outpatleni	3 DO	A Ott	hoe	ath (Check only o		ner (Specify)			
within 24 hours effer deeth.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: T	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury Work?  2 Accident Investigation M 1 Yes 2						ing Home 5 ☐ Residence 6 ☐ Other (Special 28d. Describe how injury occurred					
urs efter d trail Direct illed in by	Certific	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)								f. Location (Street and Number or Rural Route Number, City or Town, State)			
within 24 hours after deet To the Funeral Director: completely filled in by the	Medicai	29a. Certifier (Check only one)  2□ Medicat Exa  29b. Signatura and title of certifier	d at the time, date and placa, and due to the cause(s) and manner as stated.  n, in my opinion, death occurred at the time, date and place, and due to the cause(s)				cause(s)						
T CO		) V also				29c. License number 29d. Data signed (Month, Day, Year) 9-7-91				1			
		30. Name and address of person who	completed cause of death (	Item 23a) (Type, F	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jorge Abrego, MD; 660 Daffin Lane Obrego Cooperation, March Denton, Md. 21629								

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q

					Cen	tificate o	f Death		F	Reg. No.	7 30034
Physician		1. Decedent's Neme (First, Middle, La			7			2.	Dete of Des Month		3. Time of Death
/Medical Examiner	H	LYDIA VIRGI We. Facility Neme (If not Institution, given 1520 Postal	e street and number)	IAN			4b. City, To	wn, or Locat	ept 2 tion of Deeth	1 , 1 9 9 7 4c. County	of Deeth
Funeral Director		5. Sociel Security Number 6. S 219-10-8788	Sex 7. Age	(In yrs. lest b	oirthday) Yrs.	If Under 1 Yes Months Dey	r If Under:	24 Hrs. 8. Min.	Dete of Birtl (Month, De)	h v, Year)	een Anne's  9. Birthplace (Stete or Foreign Country)  Maryland
natural, or items 23a or 28a4 show digal Examinat must be notified at eted by Funeral Director		Usual Residence of Decedent 10e. State 10b. County Md. Queen		10c. City, To	wn or Loc ster				•		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
23a or 28a-f s ant be notified ai Director		10e. Street end Number 621 Dominion R	oad			10f. Zip Code 2 1	619			10g. Citizen of V	What Country?
th and Mental Hygiene.  7 le marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinet must be notified at To Be Completed by Funeral Director		11. Merital Stetus  XX Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Et Armed Forces? 1 Yes 2 No if Yes, Give Year or Detes:			es Decedent of Yes, specify Cu □ Yes 250N		gin? (Specit i, Puerto Ric	y Yes or No- an, etc.)		e - American indien, ck, White, etc. White
Hygiene. The mature out, the Medical Completed		15. Decedent's Et (Specify only highest gra Elementery/Secondery (0-12) 1 2	ducation ide completed) Coilege (1-4or 5+	+}		ent's Usuel Occ ind of work don O NOT use reti		t of working		D.Ste	wart Webb ishing Co.
e marked other purmatic event		7. Father's Neme (First, Middle, Last, Joseph Coleman							First, Middle, le Tin	Meiden Sumen	ne)
em 27 le m ther treum		19e. Informent's Neme/Reletionship ( Wesley Thompso		P	.0.	Box 6	8, Ch	ester	, Md	. 2161	Stete, Zip Code)
important: If item 27 any injury or other th		20. Method of Disposition  \$\overline{\bar{\text{S}}} \overline{\text{Burlei}} 2 \subseteq Cremetion 3 \subseteq  4 \subseteq Donetlon 5 \subseteq Other (Specif.)  21. Signeture of Funerel Service Licer	y)		ensi	ition (Name of etory or other por ot	Cemete	ery	24,19		City or Town, State  Sville, Md.
impo any de		23a. Part1. Enter the disease, or com shock, or heert fellure. List only	1011	•	Fe	llows	, Helf	enbei	n & I	Newnam ster,	Funeral Hon Md. 21619 Approximate Interval Between
rand ial-transit miner Examiner		Immediate Cause (Finei disease or condition resulting in deeth)	o. But	Due to (or as e	e consequ	Deanca of):	th	at	lue	Jun	Onset end Deeth
Wedical		Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events esulting in deeth) Last	c	ue to (or es e							
igned by the attendi		Part If. Other eignificant conditions o	ontributing to death but	not resulting	in the und	derlying cause o	given in Pert f.		23b. Did to		ntribute to the cause of death
2 should pleted	-								24a. Was a perfor	an eutopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
entific ector Be	2	25. Was case referred to medical examiner?						of Deeth (C	1 □ Y	0/	1 Yas 2 No
the funeral di cation: To		1 Yes 2 No  17. Menner of Deeth 1 Neturel 5 Pending investigation 2 Accident investigation 3 Suicide 8 Could not by		Year) 28b.	Time of injury	28c. Inj W M 1[	uryet ork? □Yes 2□t	28d	I. Describe h	enca 8 Oth	red
filled in by		4 ☐ Homicide determined	building, etc.	(Specify)					City or Tow	n, State)	er or Rural Route Number,
To the Funeral Direct completely filled in by Medical Certific			ysician: To the best of hiner: On the basis of e end menner stete	xaminetion a	e, deeth ond/or inve	stigetion, in my	time, dete end opinion, deet nse number	d placa, end th occurred	et the time, d	lete end place,	enner as steted. end due to the cause(e)  d (Month, Day, Year)
	3	0. Neme and address of person who	1 11		) (Type, P	rint)	050	, ,			2,1997
State	3	Ralph E. Libb	32. Registrer	's Signeture			nter	Rd.,	Gras	onvill	.e, Md. 2163
Registrar		SEP 23	1997 9	hia Davis	lon-A	andress			-		

1 20

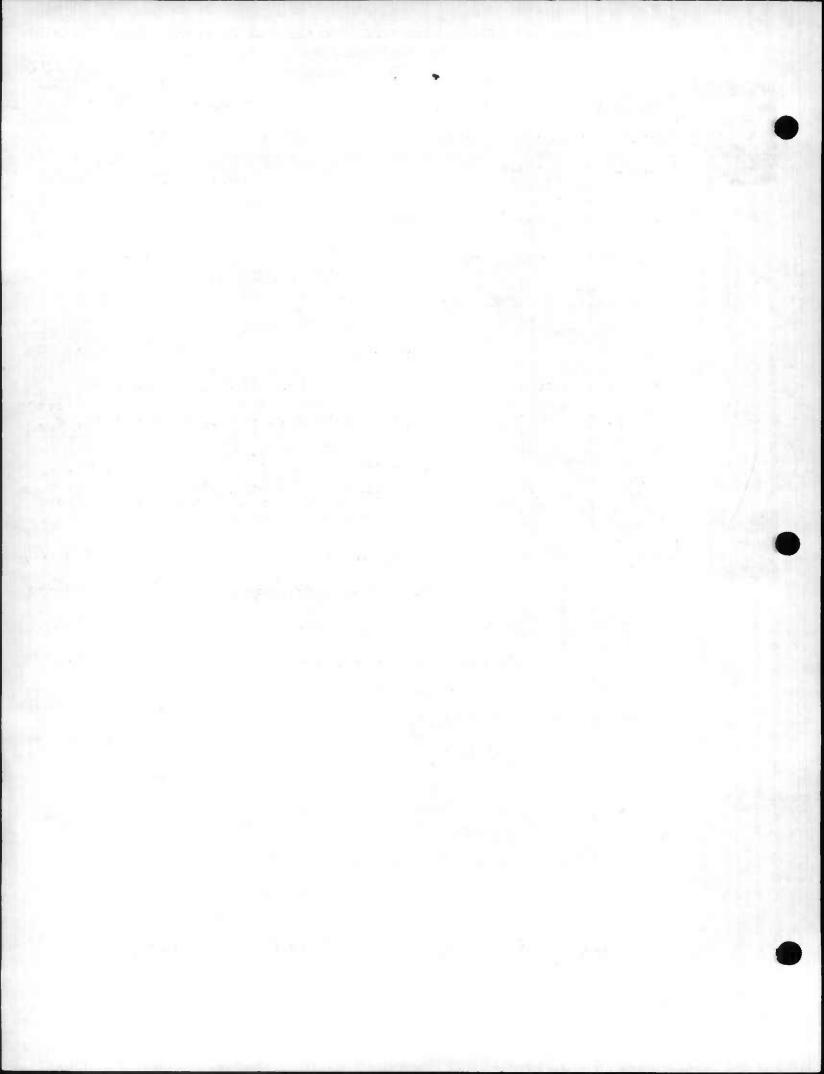
State of Maryland / Department of Health and Mental Hygiene 30655 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth September 6, Year 997 **Physician** 05:07a Franklin Cummings Duncan /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Memorial Hospital @ Easton Easton Talbot 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs.

Months Devs Hours Min. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 15 M 2□ F 75 216-14-7787 Yrs Director Aug. 16, 1922 Maryland Usuei Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natures!", or terms 23a or 25a-f show event, the Medical Examinar must be notified at Md. 1 Yes 2 NM Director Queen Anne's Grasonville 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 21638 600 Perry's Corner Road U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgln? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. DXYes 2 No tt Yes, Give Yeer or Dates: WWII 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes SENO Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglens. Elementary/Secondary (0-12) College (1-4or 5+) Seafood Ind. Waterman 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) should be nd Mental marked o Alexander Schultz Duncan Noma Violet Cummings 19e. Informent's Neme/Relationship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Deptitiment of Health is Important: If them 27 is any injury or other tra 600 Perry's Corner Rd., Grasonville, Agnes L. Duncan (Wife) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete \*Burlel 2 Cremetion 3 Removel from State Sept. 9, 1997 4 ☐ Donetion 5 ☐ Other (Specify) Md. Veterans Cemetery Hurlock, Md. Fellows, Helfenbein & Newnam Funeral Home 106 Shamrock Rd., Chester, Md. 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart taiture. List only one gause on each line. **Physician** /Medical immediate Cause (Final disease or condition resulting in death) 3/2 days cordiac ARRHYThmis Examine ELECTTOLYTE DISTURBANCE (Hyperkylemin)
Due to (or es e consequence ot): physicien end the burief-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Box 68760 CHRONIC RENAL FAILURE Completed by Physician/Medical Due to (or es e consequença of) RENAL CELL CARCINOMA Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Unknown ENCEPHALOPAThy 24a. Was en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28e. Date of injury (Month, Dey Year) 28b. Time of 28c. injury at Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Piece of injury - At home, term, street, fectory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piace, and due to the cause(s) end menner stated. Medicai 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 31867 leted cause of death (item 23a) (Type, Print) 219 S. Washongton Street Michael Fisher Easton, MD 1997 32. Registar's Signature Randens State

Registrar

Ranklin



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Brady Brinsfield Dean September 27,1997 2:45PM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Memorial Hospital @ Easton Easton Talbot If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 25,1900 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XX Days Yrs 220-16-9469 Maryland Director Usuel Residence of Decedent 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28a-f shot traumetic event, the Medical Examiner must be notified at Maryland Dorchester 1 ☐ Yes XX No Cambridge Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2256 Hudson Road 21613 Cambridge Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: White þ 3\\ Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1. Pages 1 and 2-should be filed within timent of Health and Mental Hygiene. Hapts-Millem 27 is marked other than " Elementary/Secondary (0-12) Coilege (1-4or 5+) Waterman-Farmer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2-should be next of Heeffh and Mental George S. Dean Addie Todd 19a. Informent's Neme/Relationship *(Type, Print)* Barbara Jean Windsor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand Daughter 2254 Hudson Road Cambridge, Maryland 21613 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burlai 2 Cremation 3 Removel from State ing infuny or 9/30/97 Cambridge, Maryland Greenlawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Service Licensee 22. Name and Address of Fecility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Psrt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory street, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner physiclan end s the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or es e consequence of): P.O. Box 68760, Physician/Medicai that initieted events resulting in death) Last Due to (or as a consequence of) ed by the el deteched fo Part If. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detec Records, þ 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 2 NO certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Menger of Deeth 28e. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred if or Attending P effer death. Director: After I After 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Illed in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled? edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the best of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and plece, and due to the ceuse(s) end manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HULL 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

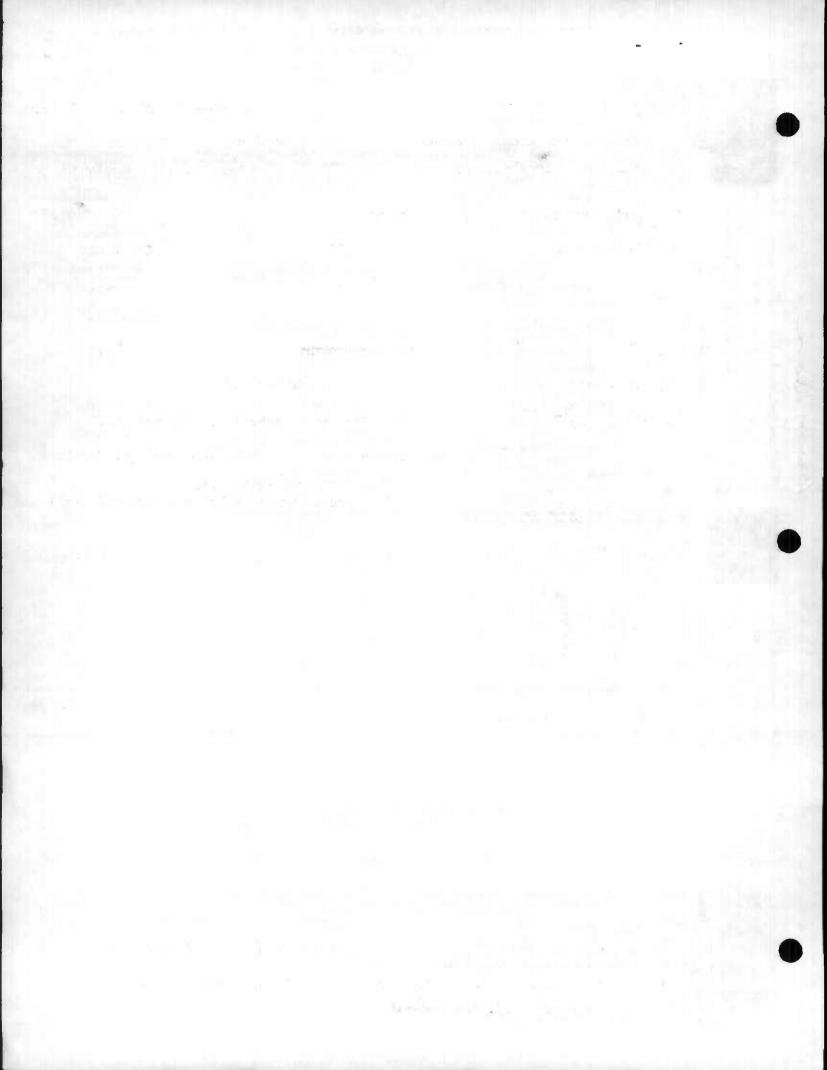
State Registrar

SEP 3 0 1997

Kathleen Hoey, M.D.

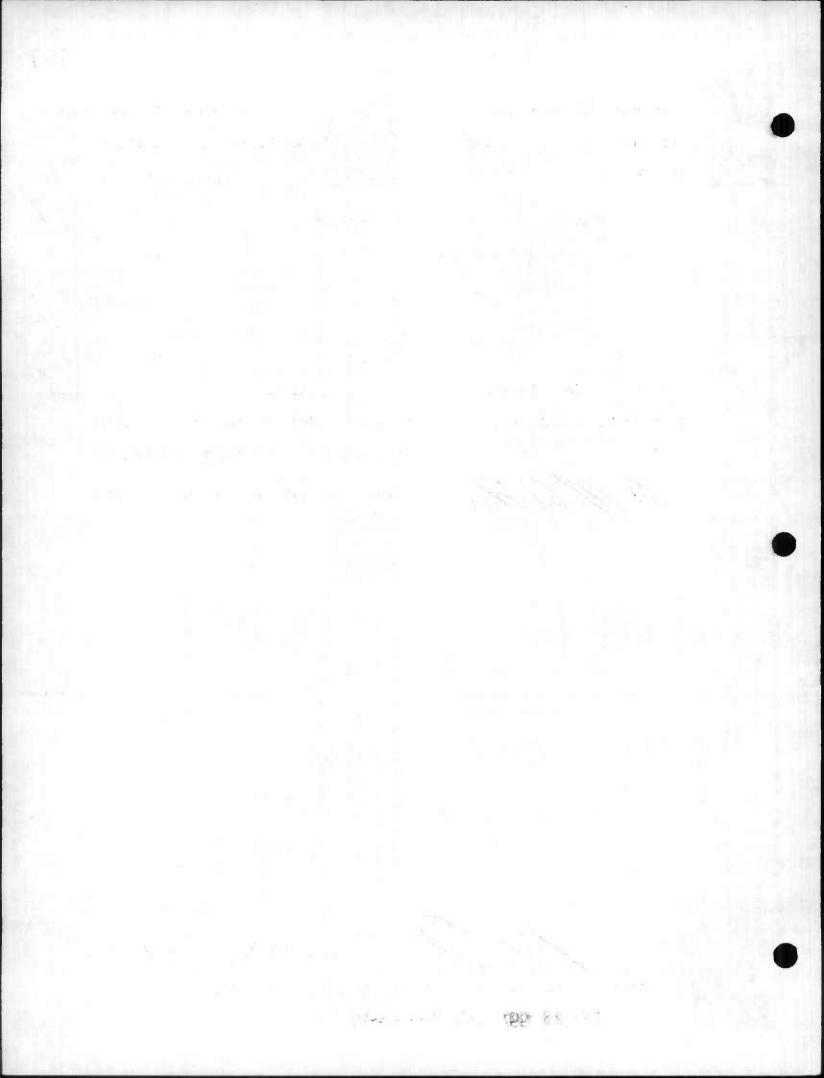
31. Dete filed (Month, Dey, Year)

207 N. Liberty Street Centreville, Maryland 21617 32/Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene 97 30657

Item:29a p	er N	D G-755 1/23/98 dh		Certificate of	Death	Re	eg. No.	00001
Division		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day Yee	3. Time of Death
Physic /Medi		Margaret Elizabeth Dov	e			Septembe		
Exami		4e. Fecility Neme (If not Institution, give street and I	number)		4b. City, Town, or Lo		4c. County of D	
		Calvert County Nursing	Center		Prince Free	derick	Calve	rt
Funeral Director		5. Social Security Number  216 22 0289  Usual Residence of Decedent  6. Sex  1 □ M 25 ₹ F	7. Age (In yrs. lest bir	thday) If Under 1 Yee Months Deys	r If Under 24 Hrs.  Hours Min.	8. Dete of Birth (Month, Day, Dec. 18		Birthplece (State or Foreign Country) Wash., DC
wo w		10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
Many Many	to	MD Calvert	Prin	ce Frederic	ck			1 □ Yes 2√ No
th with the Maryle 23e or 28e-f sho	al Director	10e. Street end Number 420 W. Dares Beach Rd	. Apt. 214	10f. Zip Code 20678		11	0g. Citizen of What USA	Country?
re, Maryland 21215-0020 s.1 and 2 should be filed within 72 hours effer death with the Maryland Heelth end Mental Hygiene. then 27 is marked other than "natural", or items 23s or 28s-f ahow other traumatic event, the Medical Examinet must be notified as	by Funeral	Armed	cedent Ever in U,S. Forces? 2 2 No Give Dates:	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spe ben, Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	14. Race - A Bleck, W Specify: W	
5-0 72 ho	Be Completed	15. Decedent's Education (Specify only highest grade completed	16e.	Decedent's Usual Occu	ipation		ss/Industry	
21 Bin Theo	npie		(1-4or 5+)	(Give kind of work done life. DO NOT use retin	ed)	ng		
21 Page No.	Cou	5		ousewife			own he	ome
in de la la la la la la la la la la la la la	Be	17. Father'a Name (First, Middle, Last)			18. Mother's Neme	(First, Middle, A	Aaiden Sumame)	
yla ould Men Men arks	T <sub>o</sub>	Lawrence Lee Jenki	ns		Alice	A		Kirby
D 5 5 5		19a. Informant's Name/Relationship (Type, Print) Jennette E. LaMond/daug		. Mailing Address (Stree 5 Terrace I				e, Zip Code) 0678
Page nent o		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removel fror 4 □ Donation 5 □ Other (Specify)	20b. Place of cameter Southe	Disposition (Name of y, crematory or other plants in Mem. Gai	dens 9-		20c. Location - City Dunkirk,	
Baltim permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Literasey	26	22. Name and Addi	ress of Facility uneral Home	e, Owing	s, MD 20	0736
Physician /Medical Examiner	ner	25a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause of immediate Cause (Final disease or condition resulting in death)		to enter the mode of dy  To life  consequence of):				Approximate Interval Between Onset and Death
I Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the buriel-transit	an/Medicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or es a c	consequence of):	<i>J</i>			
ds, P.O. Barries that the death signed by the attended for detected for	Physician/	Part II. Other significant conditions contributing to	death but not resulting in	the underlying cause g	iven in Part I.	23b. Did to	bacco use contrib	ute to the cause of death?
P.O. het the detached	£	A				1 🗆 Y	8 2 No 3	Probably 4 Unknow
of Vital Records, Physician: The law requires th this certificate has been signed and director, page 2 should be d	Completed by	Chance O	6 streetive	Pylmona	Discussi	24a. Was ar	ned?	b. Were autopsy findings available prior to completion of cause of death?
						1 □ Ye	s 2ENo	1 ☐ Yes 2 ☐ No
f Vita yslclan: s certific director,	Be	25. Was case referred to medicat examiner?		10	26. Place of Death			
Phys al dia	. To	10 165 20100	Inpatient 2 ER/Ou	tpatient 3 DOA	Nursing Hon			pecify)
After fune	Certification:	2 Accident investigation 3 Sulcide 6 Could not be determined 28e. Place			Yes 2□No			Rural Route Number,
Divisi To the Hospital or Attendations within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only one)   1 Certifying Physician: To the (Check only one)   2 Medical Examiner: On the end many one)   1 Certifying Physician: To the control of th	basis of examination and	, death occurred at the t dor investigation, in my	ime, date and place, a opinion, death occurre	nd due to the ca	ause(a) and manner ate end place, and c	ss stated. lue to the cause(s)
ithin ithe	Mec	29b. Signature and title of certifier	nner stated.	29c Licen	se number	20	9d. Date signed (Mo	onth. Dav. Year)
F 3 F 8		1/1	011		33123	,	9-24	97
6		30. Name and address of person who completed car			-1	0.676		
Sta	_		Registrar's Signature	nce Frederi	.ck, MD 2	0678		
Regist	ar	SEP 26 1997	Jalia Davide	ion hardall				



Dharaia		1. Decedent's Neme (First, Middle, I	ast)	F/17			2. Dete of Deat	_	Vane	3. Time of Deeth
Physic /Medi Exami	cal	Charles Milt 4e. Fecility Neme (If not institution, g		r, Jr.		4b. City, Town, or L	Septemb	er 25 4c. County	1997 of Death	0031
	Ш	Washington Co				Hagersto	wn	Wash		
Funeral Director		5. Sociel Security Number 6. 219 14 8341 Usuel Residence of Decedent	Sex 1⊠ M 2□ F 7. Age 72	(In yrs, lest birthday, Yrs.	Months Dey	s Hours Min.	8. Dete of Birth (Month, Dey, Ictober 10	Yeer) 1924	9. Birthp Coun Manyl	plece (State or Foreign ntry) and
Aanyland I show	o.	10a. State 10b. County		10c. City, Town or L					1	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
the A	Director	Maryland Washi	ngton	Hagersto	10f. Zip Code		10	Og. Citizen of \	What Coun	
h with		18802 Dover Dr	ive		217	42		USA		,
within 72 hours after death with the Manyland with in the manyland and. than "natural", or items 23s or 28s-f show the Weddell Examine the incitited at	y Funeral	11. Maritel Stetus 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ender Armed Forces? 1 ☑ Yes 2 ☐ Note of Yes, Give		Was Decadent of If Yes, specify Cu	f Hispenic Orlgin? (Spuban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Bie	e - Americ ck, White,	etc.
72 hours natural,	ed by	3 Widowed 4 Divorced	Year or Detes: W	W 2						
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0 = 0 =	ToB	Charles Milto	n Danzer	, Sr.		Anna	Mae Fr	eeman		
d 2 should h and Men 7 is marke traumatic		19a. Informent's Neme/Relationship	(Type, Print)	19b. Meil	ing Address (Stre	et end Number or Rur	rel Route Number,	City or Town,	State, Zip	Code)
t of Hear		Louise M. Danz 20a. Method of Disposition 1 Durial 2 Cremetion 3	Removel from State	cametery, cre	emetory or other p					2174,2 own, Stete
Department Infoortant any Injury		4 Donetion 5 Other (Spec	ify)			matory 9	/27/97H	lagers	town	, Maryla
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Physician			_	^					- 1	Onset end Deeth
/Medical Examiner		Immediate Cause (Final disease or condition resulting In death)	. Card	yea 1	arri	7thmio	1			Hours
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cuted	Examiner	Sequentially list conditions	b. Cuic	ue to (or es e conse	quença of):	hair	yux		1	MICON IN
e exe		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events				·	t			
eath certificate be executed attending physician and for use as the bunal-transit	an/Medical	thet initiated events resulting in deeth) Lest	CD	ue to (or es e consec	quenca of):				i	,
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that the deaded by the a	Physici	Pert II. Other significant conditione	contributing to death but	not resulting in the u	underlying cause (	given in Pert I.		baccouesco s 2□No		the cause of death?
es that igned b	by P							2 Z NO	3[] 1101	adiy 4 polikilowi
aw requir	Completed						24e. Wes er perform	n eutopsy ned?	COL	ere eutopsy findings elleble prior to mpletion of cause deeth?
F # 8	Соп						1 □ Ye	s 2000	10	Yes 2□ No
Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical exeminer?	Hospitel:			26. Plece of Deet	h (Check only one	9)		
this did	.: To	1 Yes 2 No	1 L Inpatient		HIL SLI DOA		me 5 Reside	The last transfer of the last		1)
Attending For death.  Befor: After by the funer	tion	1 ☑Neturel 5 ☐ Pending 2 ☐ Accident investigati	28e. Dete of Injury (Month, Dey	Yeer) Injury	W	ork? □ Yes 2 □ No	Zod. Dodolioo no	wanjary bood		
To the Hospital or Attending Within 24 hours after death within 24 hours after death completely filled in by the fune completely filled in by the fune	Certification:	3 Suicide 6 Could not determine		y - At home, farm, st (Specify)	treet, fectory, offic	9	28f. Location (Sti City or Town	reet end Numb , Stete)	er or Rure	I Route Number,
To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical (	29a. Certifier 1 Certifying P	hysicien: To the best of miner: On the basis of e and menner state	xeminetion end/or In	th occurred et the ovestigetion, in my	time, dete end plece, oplnion, deeth occur	end due to the ca red et the time, de	use(s) end ma ate end placa,	anner as st end due to	eted. the cause(s)
within To the comple	Me	29b. Signeture and title of certifier			A.	nse number		d. Date signe		
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		30. Name and eddress of person who	trro mo	-1282	Print)	121457	VE. H	4 GE	250	w~.wŋ
Sta Registr	- 3 - 1	31. Dete filed (Month, Dey, Year) SEP 2.9	1997 32. Registrar	s Signature		1				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

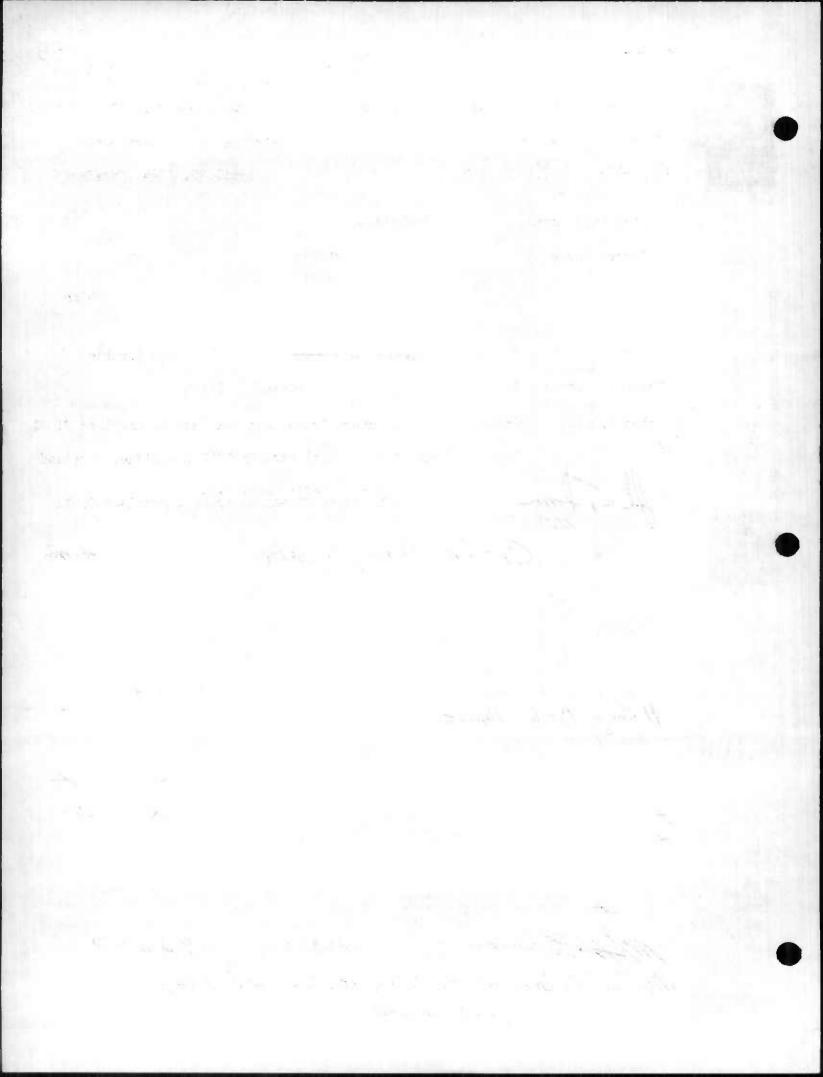
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 7

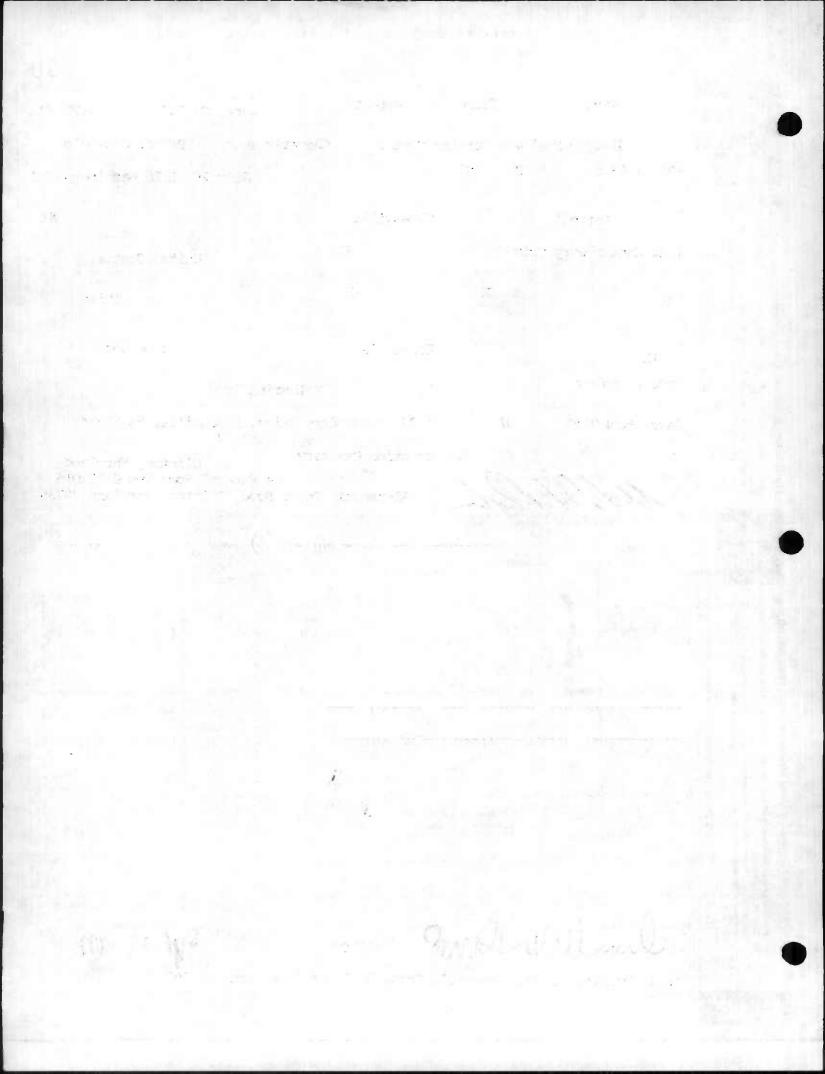
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		- 55	1 Decedent's Name (First Mid-	tle ( ant)		Ce	ertificate	e of	Death		Reg. No.		0.75
	Physic	ian	Decedent's Name (First, Midd			7	71 m =			2. Date of Dea	Day	Year	3. Time of Death
	/Medi		Raymo		ayne	1	Elms				ber 25,		Unknown
	Exami	ner	4a. Facility Name (If not institution	Control of the Contro	um <i>ber</i> )				4b. City, Town, or L		4c. County	of Death	
1			612 Greenwood						Cambr	idge	Do	rches	ter
	Funeral Director		5. Social Security Number 214–42–7528	6. Sex. PEAM 2□ F	7. Age (In yrs	s. last birthday Yrs.	Months	Days Days	Hours Min.	8. Date of Birt (Month, Da April 20	y, Year) 0, 1944	9. Birthr Cour Mar	plece (State or Foreign http:/ yland
	pu ,		Usual Residence of Decedent  10a. State 10b. Count		100.0	City, Town or L							
	Maryla H show	to	Maryland Dorch	,	106. 0	Cambi						1	10d. tnside City Limits 1XXYes 2 ☐ No
	7.28 100	100	10e. Street and Number				10f. Zip (	Code			10g. Citizen of Wha		ntry?
	3a o	0	204 Aurora Str	reet				216	513		US		
	Jeath 2	Jere	11. Marital Status	12. Wes De	cedent Ever in	U,S. 13.	Was Decede		Hispanic Orlgin? (Sp en, Mexican, Puerto	ecify Yes or No-			en Indien,
Maryland 21215-0020	s 1 and-2 should be filed within 72 hours efter death with the Maryland If Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🗓 Divorce	H Von G	2/1/No Sive		If Yes, speci			Ricen, etc.)		Specify: White	
5-0	72 ho	ted	15. Decede	nt's Education	4)	16a. Dece	edent's Usual	Isual Occupation			16b. Kind of B	usiness/In	dustry
21	Pan "	Completed	Elementery/Secondery (0-12)	est grade completed College	(1-4or 5+)	life.	DO NOT use	e retire	during most of work d)	ang			
21	P-Should be filed within end Mental Hygiene. Is marked other than aumatic event, the M	0	9			Plum	ıber				Const	truct	ion
pu	oth A	Be (	17. Fether's Neme (First, Middle						18. Mother's Nam	e (First, Middle,	Maiden Surnan	n <i>e)</i>	
<u>a</u>	Alenta Alenta rked tic e	To	Charles Her	man Elms	3				Dorinda	a Ellic	tt		
ary	N Pu		19a. Informant's Neme/Relation	ship (Type, Print)		19b. Mall	ling Address	(Street	and Number or Rui	rei Route Numbe	er, City or Town	State, Zip	Code)
Σ	27 le		Charles E. Elm	s Broth	er	4203	Satur	n I	Drive Fact	- New Ma	arket N	Jary 1	and 21631
Baltimore,	If Health Item 27 I		20e. Method of Disposition		20b.	Place of Disp	osition (Nam	e of	orive Edsi	Date	20c. Location		
no	permit. Pages Depertment of I Amportant: If ite any injury or of		X Burial 2 Cremation 4 Donation 5 Other (	3 Removal from	State Do	cemetery, cre	er Men	ner pia 10 mi	al Park	9/29/97	/29/97 Cambridge		Maryland
	rian plant		21. Si n tu st/Funeral Service	-			2. Name end			9/29/97 Cambridg		ige,	rial yland
Ba	Dependit.		21. State to Turibial Service	Licerisee					neral Home	P.A.			
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			23a. Part / Enter the disease, of share, or heart failure. Lis	r complications that tonly one cause on	caused the dea	ath. Do not er	nter the mode	of dyli	ng, such as cerdiac	or respiretory ar	rest,		Approximate Interval Between
	Physician				11 12		1	1	1				Onset and Death
	_/Medical	Н	Immediate Cause (Finel disease or condition	CA	ndin	c. H	2741	11	min				4 min
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ć	exec In an riel-tr	EX	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events		24010	(0. 00 0 001100	4401100 01).						
68760,	sicia bul	cai	Cause (Disease or Injury that Initieted events	c	Duo to /	or as e conse	auceae eft.					-	
89	tificet ng phy as th	Medicai	resulting in death) Lest		Due to (	or as e conse	quence or).					-	
	certi	3		d									
Вох	The law requires thet the death cer ate has been signed by the attendin page 2 should be deteched for use	Physician/											
0	thet the de led by the a deteched t	ysi	Part II. Other aignificent conditi			_	underlying ce	use giv	ven in Part I.				the cause of death?
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Records,	signed d be def	b	7/	, - / - /	,,,,,,							Τ	
0	v require been si should	Completed									an autopsy med?	ev	ere autopsy findings allable prior to
ec	has by	pid										of	mpletion of cause deeth?
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Vital		0	25. Was cese referred to medica	1					28. Piece of Deet	h (Check only o	nel		
>		To B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatie	ent 3 DOA	Oth	oer.	me 5 Resid		er (Specif	61/000
o	Physic this seal d		27. Menner of Death	28e. Dete	of Injury	28b. Time		c. injui		28d. Describe h			YI CAP Z
Division	Attending is or death. ector: After by the funer	Certification:	12€ Saturel 5 ☐ Pendi 2 ☐ Accident Invest		nth, Day Year)	Injury	М		rk? Yes 2 □ No				
S	or Attendi effer death Director: A d in by the f	lica	3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At I	home farm st				28f Location /9	Street and Num!	her or Rurs	al Route Number,
.≥	or A efter Direction	T	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)						City or Tow	m, State)	207 O7 7 1016	irrodio ribilioor,	
	To the Hospital or Atter within 24 hours effer des To the Funeral Director completely filled in by th												
	Fun Fun tely	edical		Examiner: On the b	pasis of examin	etion end/or ir	n occurred at nvestigation, I	n my c	me, dete end place, ppinion, death occur	and due to the d red at the time, d	dete end place,	anner as s end due to	tated. the ceuse(s)
	the hin	Mec			nner stated.		000	Linene	se number		ood Data signs	d /Adamath	Day Varal
	5 ₹ 5 8		29b. Signeture end title of certific	-							29d. Dete signe		
			111/11/19	-			D.	16.	388		726	7/	
			30. Name and authors of person	who completed cau	ise of death (Ite	m 23a) (Type	, Print)	1	388 bcl 11	0	,		
			Michnel Fr	elthew 1	10 30	20111	ns, h	ter	bol A	d 21	643		
	Sta	te	31. Date filed (Month, Day, Year,		Registrar's Sign	nature o	1 11						
	Registr	ar	SEP 3	0 1997	alia obliv	who have	Hall						
		-											



State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's	Neme (First, Midd	fle, Last)					of Death	2. Data of D	Reg. No.	97	306 ( 3. Time of D			
an ai		Mabel		Ire	ne	Er	nbrey		Sept 2	2. 1997	Yeer	4:20 1			
er	4a. Facility N	ame (If not institutio	on, give str	reef end number)				4b. City, Town, o			y of Deeth				
	6 Casial Cas	Glady's	s Spe	llman Nu	rsin	g Cente	er	Cheverly		Princ	-				
		2 8345	6. Sex 1□ N		81	lest birthday) Yrs.	If Under 1 Ye Months De		n. (Month, L	lirth De <i>y, Year)</i> 20, 1916	9. Birthp Coun Wash	leca (State or I try) ington			
	Usuel Reside	nce of Decedent 10b. County	,		10c Cit	y, Town or Loc	atlon								
Funeral Director	MD	Carro			100. 01	Skyes					"	0d. Insida City 1 ☐ Yes 2			
	10e. Street a	nd Number Canterbur	crez D	rive			10f. Zip Cod	.784		10g. Citizen of	What Coun				
	11. Marital St			. Was Decedent E	uor in II	C 42 W			0	United					
	1 Nave	rMerried 2☐ Man wed 4☐ Divorced	ried	Armed Forces?  1 Yes 27 N  if Yes, Give Yeer or Dates:		J,S. 13. Was Decedent of H If Yes, specify Cuba  1  Yes No			specify Yas or N irto Rican, etc.)	14. Reca - American Indie Bieck, White, etc. Specify: White		etc.			
eted		15. Deceden (Specify only highe	nt's Educat	tion		16e. Decede	ent's Usuel Oc	cupetion	orkina	16b. Kind of B	usiness/Ind	lustry			
Completed by	Elementery	/Secondary (0-12)	J. G.	College (1-4or 5	+)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of life. DO NOT use retired) Housewife		orking	Home	Homemaker				
Be C		lama (First, Middie,	Last)					18. Mothar's N	eme (First, Middl	e, Meidan Suman	Jame)				
ToE	Josep	h Caslow						Katheri	ne Lowe	2					
	19e. Informa	nt's Neme/Raiations	ship (Type,	Print)		19b. Mailing	Address (Stre	eet end Number or F	Rural Routa Num	ber, City or Town,	State, Zip	Code)			
		Funk (SON	1)		1						City or Town, State, Zip Code)  ille, Md 21784  Oc. Location - City or Town, State				
	20e. Method o		Isposition   20b. Pleca of Disposition (Name of Sept 27)   2 Cremetlon 3 Removel from State   Resurrection Cemetery					, 19997	20c. Location - City or Town, Stete						
		tion 5 Other (S			Res			_	Clinton, Maryland						
									ee Funeral Home, Inc 6633 Old Road, Clinton, Maryland 2073						
	23a Parti E	nter the disease or		land that anyone	the death			_		•	aryıa				
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	Immediate Ceuse (Fine)  METASTATIC RECURRENT OVARIAN (														
	diseese or co resulting in de	eth)	8		Due to (o	r es a consequ	enca of):				1				
lner			<b>a</b> b												
Medical Examiner	Sequentially if eny, leeding cause. Enter Ceuse (Disee		Due to (or es a consequenca of):												
dica	THE MILLEGE C	euse (Disease or injury et inflieted events  Dua to (or es e consequenca of):													
Me	d								i						
Physician/	Dad II Other	Dod II Olban Jan Man Andria													
hys	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.							23b. Did tobacco use contribute to the cause of deat							
by Pt			WASTI	WASTING SYNDROME, HYPATIC METS, SEROSAL METS,						TOTAL ZE NO SOPROBEDIY 4 ORK					
6	PANCYTOPENIA, HYPOADRENALISM 2ND TO CANCER						24e. We:	s an eutopsy formed?	n eutopsy med? 24b. Were autopsy findings availeble prior to completion of cause of deeth?						
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completed by	PANCS	TOT CHITY,							10	Yes 2 No	1 🗆				
e Completed	25. Wes case	referred to medical						28. Place of De	1 □	0 1171	1 🗆	TOO EEPING			
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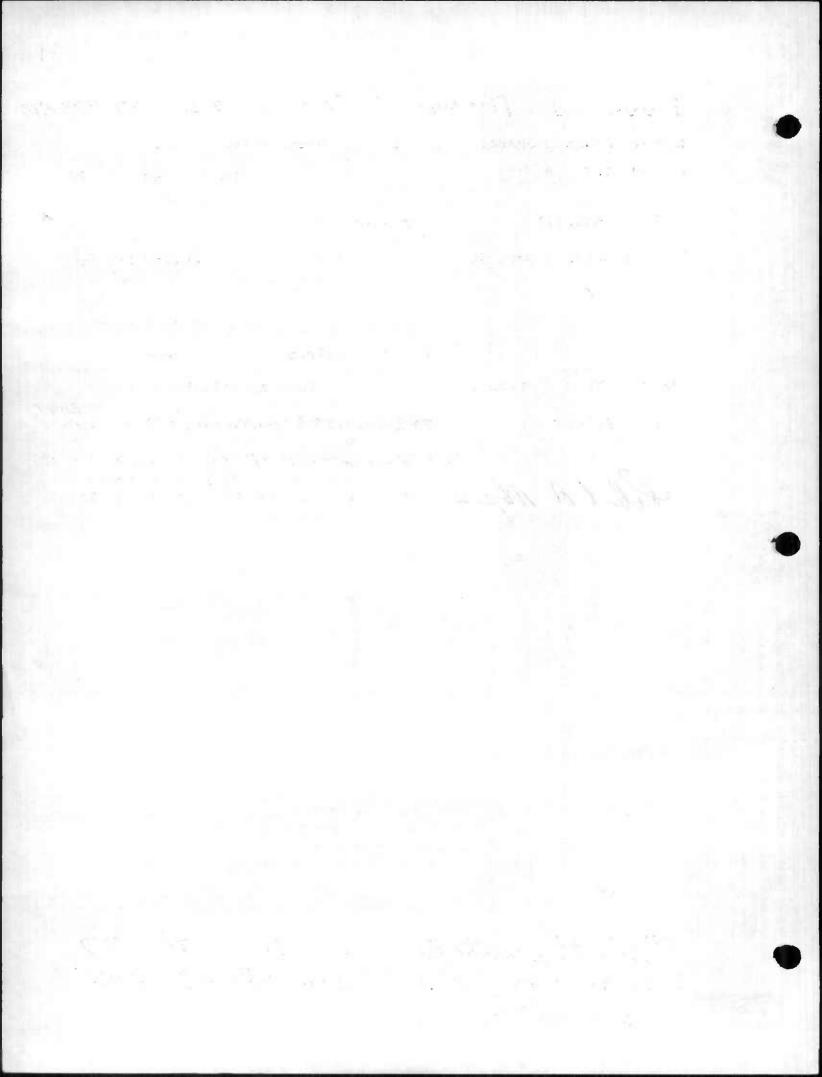
				State of Ma	ryland						lental H	ygiene	) /	30661
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	Physic /Medi		Raymond	The	oma	25	Fr	11	5	JK	Month	23	9°AT	903 AM
,	Exami		4e. Fecility Neme (If not institution, gi	ve street and number)	Thomas Fritz JR 2. Deter of Death Months 2 day year 903 AM 4b. City, Town, or Location of Death Months 2 day year 903 AM 4b. City, Town, or Location of Death Age (in yes. last birtholey) 15 Under 1 Year 15 Under 24 ths. 8. Deter of Birth Year) 9 Birthplace (Site or Foreign World, Day, Year) 9 Birthplace (Site or Foreign World, Day, Year) 10d. Inside City Limits 1 Under 1 Year 15 Under 1 Year 16 Under 24 ths. 8. Deter of Birth Year) 9 Birthplace (Site or Foreign World, Day, Year) 9 Birthplace (Site or Foreign World, Day, Year) 9 Birthplace (Site or Foreign World, Day, Year) 9 Birthplace (Site or Foreign World, Day, Year) 10d. Inside City Limits 1 Ures 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day 3									
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Г	Funeral			Sex 7. Aga 1⊠M 2□F							8. Dete of B	irth Pay, Year)	9. Birth	place (Stete or Foreign
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	and w	]	Usuel Residence of Decedent  10a, State 10b, County		10c City	Town or Lo	cation						1.	10d Incide City Limite
	Aaryla	ŏ	MD Carro											The state of the state of
	the A	Director	10e. Street and Number	11	WE	stml						40a Obinas et	Mark Com	
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320	Ir, or	by I	3 ☐ Widowed 4 ☐ Divorced	if Yes, Giva Yaer or Detes:		1	☐ Yes	2√ No	Specify:			Specif	y: Wi	nite
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21	TI CO. L.	mo.	12	College (1-401-54	,	Fore	man/	'Mai	lroo	m		Book		
pu	be filed itel Hygi d other avent, t	Be	17. Fether's Neme (First, Middle, Last		18. Mother's N			er's Neme	Neme (First, Middla, Meiden Surnem			10)		
/lai		To	Raymond Thoma	s Fritz S	Sr.				Dor	om Book her's Neme (First, Middla, Meiden Sumeme) rothy Elizabeth Royer ber or Rural Routa Numbar, City or Town, Stete, Zip Code) 21. CHARCH ED WESTMINSTER, M. Data 20c. Location - City or Town, Stete ry 9/26/97 Union Bridge, dility 91 Willis Street 1 HomeWestminster, MD 2115	er			
Maryland	d 2 should th and Man 7 is marke traumatic		19e. Informent's Name/Reletionship	Type, Print)		19b. Meilin	g Address	(Street	and Numb	er or Rura	i Routa Num	bar, City or Town	, Stete, Zip	Code) 21157
	5 % CI F		Mary E. Fritz/	Wife		742			RS	CHA	ECH R	D WETT.	71257	ER, MD
ore	(A O		20a. Method of Disposition 1  Burial 2 ☐ Cremetion 3  E	Ramoval from State	20b. Pled	e of Disponence etery, cren	sition (Nen netory or o	na of thar plac	e)		Data	20c. Location	- City or To	own, Stete
Ë	artment of ortant: If its injury or o		4 ☐ Donetion 5 ☐ Other (Speci	<i>y</i> )	Pip	e Cr	eek	Cem	eter	y 9,	/26/9	Unio	n Br	idge, MD
Baltimore,	pemit. Peges Department of Important: If is any injury or pace.		21, Signeture of Funeral Service Lica	nsea /		22	. Nama an	d Addres	s of Facili	ty	91 V	Villis	Stre	et
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r			23a. Pert1. Entar the disaese, or com- shock, or heert failure. List only	plications that caused to	the deeth.	Do not ente	er the mod	e of dyin	g, such es	cardiec o	r respiretory	errest,		Approximate
S.	Physician												i	
d	/Medical Examiner		Immediate Cause (Final disaasa or condition	Ventr	ICU	lar	- 1	E,1	bril	1/4-	tion			27 min
	LAGIMME		resulting in deeth)	0 10	ue to (or e								i.	7 /
	ed sit	Examiner		Hnte	VION	~ /	nyo	200	red	10/	In	faveti	つり	1 days
	cata be axecuted physician and the buriel-trensit	хал	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	ue to (or e	s e conseq	uence of):							
8760,	be a siclar	dical	cause. Enter Undertying Ceuse (Diseesa or injury that initieted events	C										
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00	7 00	olet									per	formed?	00	railable prior to empletion of cause deeth?
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ta		Be C	25. Was case referred to medical	2,0,0		1	/ (	`	26 Place	of Deett	(Check only	THE COLUMN	1	2010
	Physician: r this cartific rral director,	ToB	examiner?	Hospitei:	t 2□ER	VOutpatien	3□ DC	A Othe	er.			sidence 6 Oth	ner (Specil	(v)
0	문 # 를		27. Manner of Death	28e. Dete of Injury (Month, Day	28	b. Time of		8c. Injury Work				how injury occur		,,
Division of	Attending In death.	atlo	1 Natural 5 Pending 2 Accident investigatio	n	, oar,	Injury	M		Yes 2□	No				
<u>≅</u>	or Attendation of Director:	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injur- building, etc.	y - At home (Specify)	e, farm, stre	et, fectory	, offica			28f. Location	(Street end Numi	ber or Run	al Route Number,
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Med	one)	and mannar state	ed.									
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			(bluil)	Lichell	On/	1		25	92	76		7/2	3/ 1	
			30. Name and eddress of person who	completed causa of dee	eth (Item 23	Ba) (Type, I	Print)	60	+mi	nss	les 1	MD	211	57

State Registrar

31. Dete filed (Month, Day, Year)

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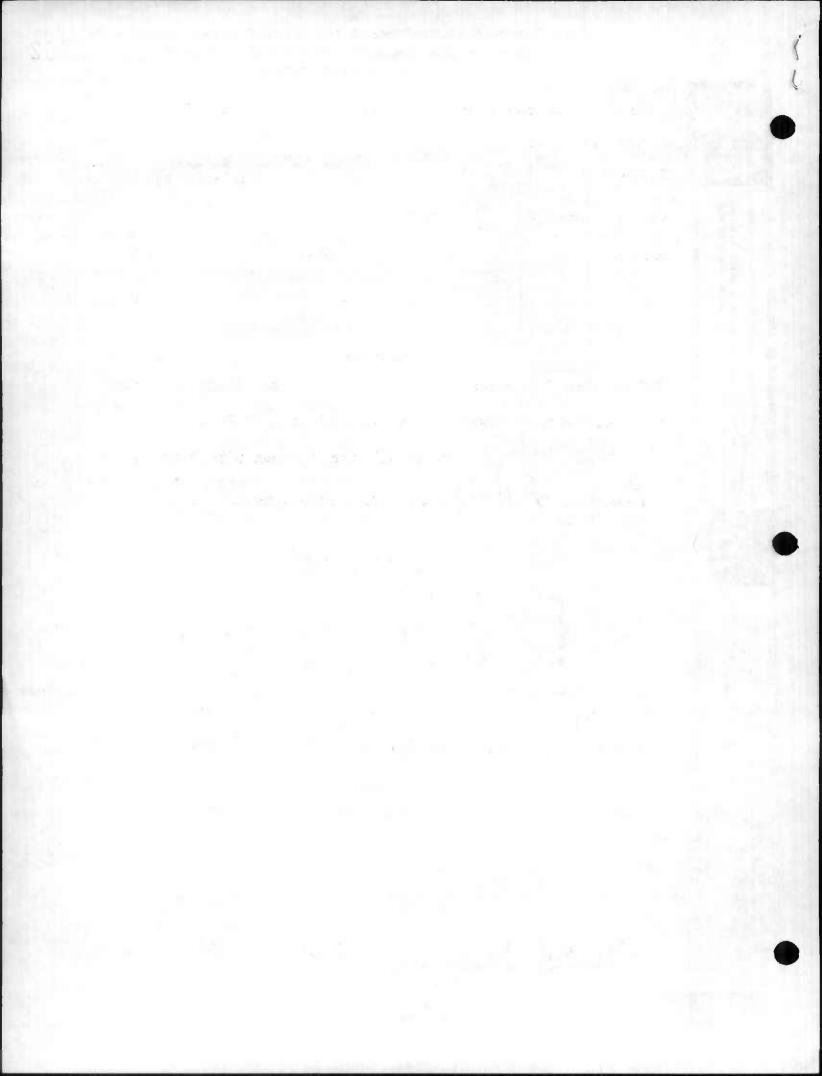
32. Registrer's Signeture
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State of Maryland / Department of Health and Mental Hygiene 9

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Physician /Medical	_	JOYCE	ART	Fees	ser					20 ั 1997	0 1997 Year																	
/Medical Examiner	-	4a. Facility Neme (If not institution	n, give street and							4c. County of Deeth		8am																
	4	6250 Shawn	+									arrol																
Funeral Director		5. Social Security Number  220–12–4131  Usuel Rasidence of Decedent	6. Sex 1 ☐ M 2 ☐ X		rs. last birthday) Yrs.	If Under Months	Days		Min,	8. Date of Birth (Month, Dey Nov. 13	1924	Coun	isce (State or Forei try) yland															
r 28a-f show notified at		10a. Stale 10b. County			City, Town or Lo							1	0d. Inside City Limi															
or 28=4 si	3	VA Accomack Harborton  10e. Street and Number 10f. Zip Code						T	10g. Citizen of Whet Country?																			
23ª or	8	Box 104				2338				U.S.A	٨.																	
natural', or itema 23a or 28a-f show atcal Examinat must be notified at sted by Funeral Director	se completed by	2	2	11. Marital Status  1 □ Never Married 2 Nan 3 □ Widowed 4 □ Divorced	Armed Tiled 1 Tye If Yes,	es 2V No						ecify Yes or No- Ricen, etc.)	Bla	e - Americ ck, White, White	etc.													
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Department important: any injury once.										_	ight Funeral Home & Chape lle MD 21784																	
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ate hes been signed page 2 should be																			ire Gro Un							24a. Was e perfor	en eutopsy med?	ave
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certificate rector, pag		25. Wes cese refarred to medica						26. Place	of Deat	th (Check only or	ne)	1																
S & S		examiner? 1 Yes 2 No	Hospital:	☐ Inpatient 2	☐ ER/Outpetie	nt 3 DO	)A Ot	her: 4 🗆 Nu	ırsing Ho	ome 5 Resid	ence 8 🗆 Ott	ner (Specif	y)															
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C 2 0 M		29b. Signature end title of certifie	or .			29c	. Licen	se number		2	9d. Date signe	d (Month,	Dey, Year)															
within To the comple	1	/ / /	1	0 04			1				0																	
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30663 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 25 200 enla 30 35 /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location 4c. County of Deeth Examiner Cour 7. Age (In ws. last birthdey) 1215 5. Social Security Number If Under 1 Year 6. Sex 8. Dete of Birth (Month, Dey, Birthplece (Stete or Foreign Country) **Funeral** Year) NEW 20 F Months Deys Hours Min 325-01-5479 **Director** NOV Illinois Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location mast be notified at 10d. Inside City Limits Yes 2 No Director Florida Lee Boca Grande 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? deeth with 1031 Tenth Street 33921 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Nems 11. Maritei Status Was Decadent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. the Medical Examiner filed within 72 hours efter 1 Never Married 2 Married 21215-0020 ò white 1 Yes 2 X No Specify: þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Institutional Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Food Processing 12 Chairman of Board other traumatic event, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be h end Mental I Began 1 and 2 should be Charles B. Hill Mary Inez Pettibone 2 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) nt of Health e Charles B. Hill, III 4762 Antler Trail, Sarasota, Fl. 34238 other altimore 20b. Piace of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 🗷 Cremetion 3 ☐ Removei from Stete 6 Incomment important: I any injury o 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown Crematory 10-1-97 Hagerstown, Maryland 21. Signeture of Furniral Service Licensee 22. Name end Address of Fecility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Onsel end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) **Examiner** Due to (or es e consequenca of) Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest buriel-trail Due to (or es e consequenca of): Box 68760, physician the Due to (or es e consequenca of): USB BSU P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of desth? 2 1 Yss 2 No 3 Probably 4 Unknown sate hes been signed page 2 should be de Records, þ 24b. Were sutopsy findings evelleble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate of Vital or Attending Physician: director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) exeminer? Hospitel: 1 ☐ Inpatient 2 DER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) P 1 Ves 2 No 27. Menner of Deeth 28b. Time of Injury Certification: Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred After Division 5 Pending Investigation 1 Neturel 1500M 2 Accident 301997 0 to well her s efter death completely filled in by the 3 Suicide 6 Could not be Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) n (Street end Number or Rurel Route Number, Town, Stete) 281. 4 Homicide solve hay 0 To the Hospital within 24 hours e To the Funeral D 1 Certifying Physicisn: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mather as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier

29c. License number

32. Registrarie Signature

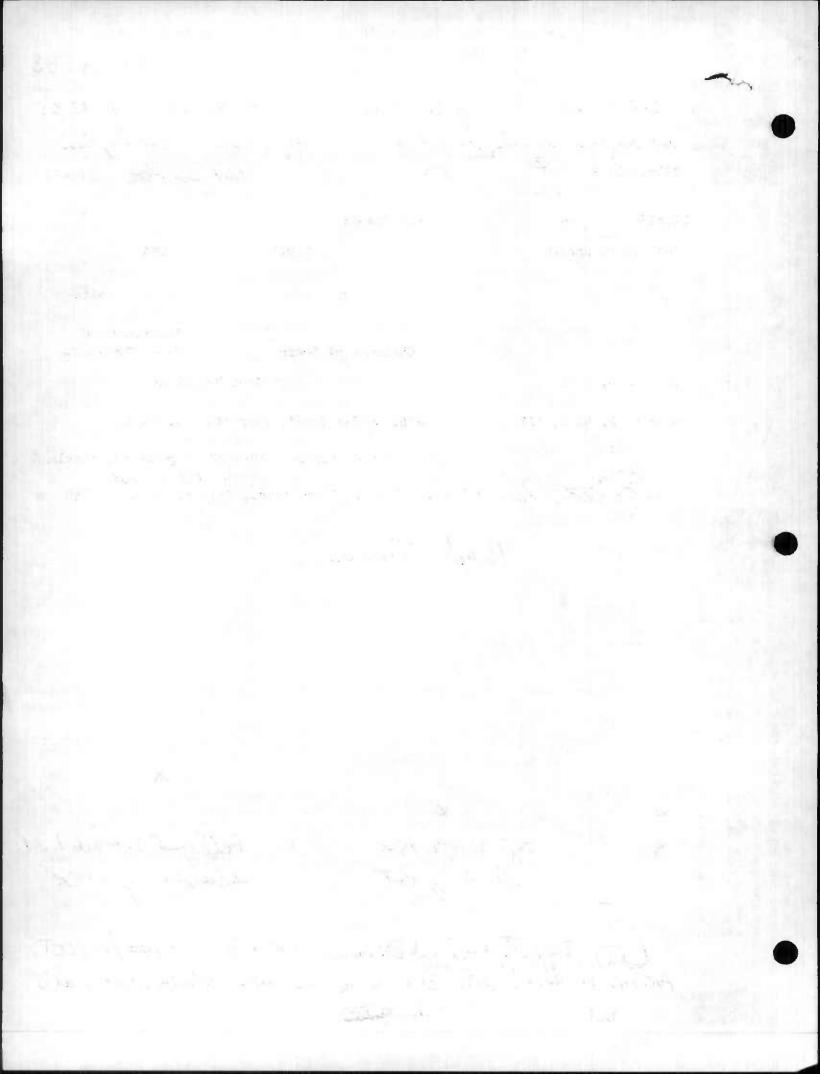
29d. Date signed (Month, Dey, Yeer)

State Registrar

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

30. Name



						UE	ertificate o	Dealli			Reg. No.		
ician		's Name (First, Mide CHA	dia, Last) RLES	F	REDERIC	CK	HODDE			2. Date of De Month SEPT	26 19	Year	3. Time of Death 12:38PM
dical niner	An Paulita at	lame (If not instituti	on, give street	end nur	m <i>ber</i> )			4b. City, To	wn, or Lo	ocation of Deall		y of Death	
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al or	213-	14–6478	6. Sax	20 F	7. Age (In yrs. 74	. lest birthday Yrs.	Months Day		24 Hrs. Min.	8. Date of Bir (Month, De Aug. 1	th ey, Year) 5 1923	9. Birth Cou Mary	place (Steta or Foreign intry) 'land
	Usual Resida	ance of Decedent 10b. Count	v		10c Cit	ity, Town or L	ocation						10d Incide City I inite
ō	100 200	100	hester		, 55. 5.		mbridge						10d. Inside City Limits Yes 2 □ No
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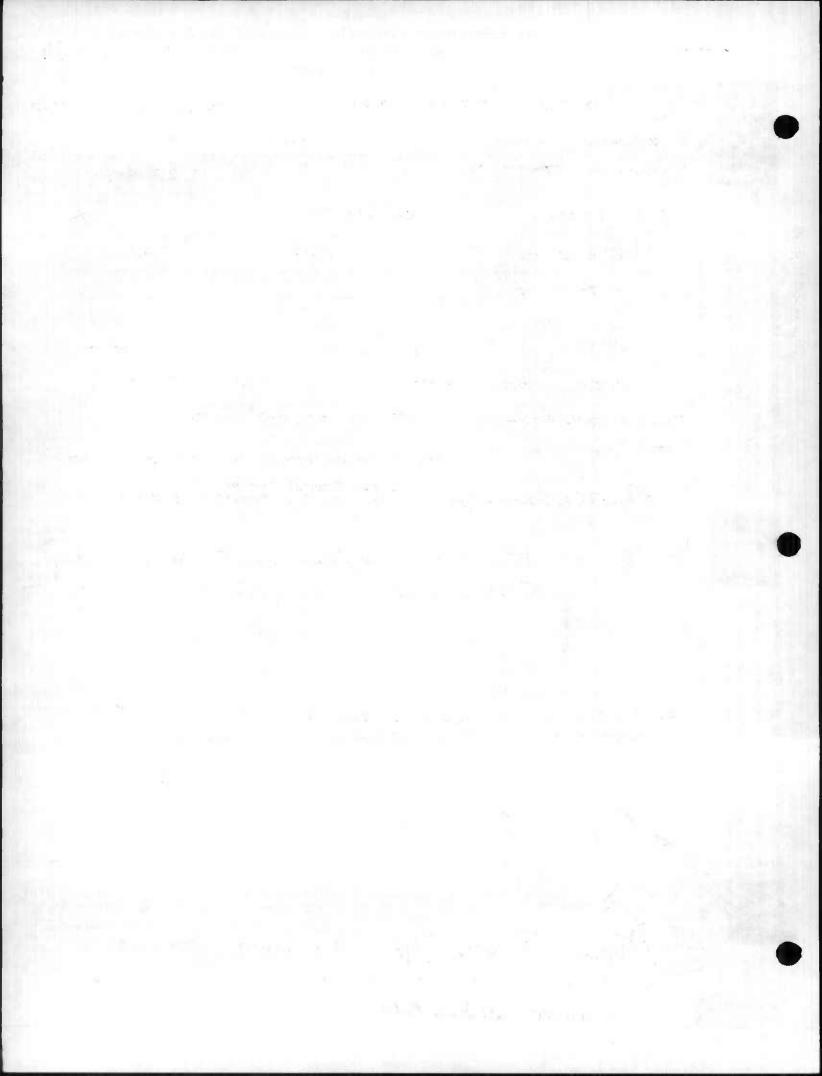
32. Begistrar's Signature Rawlell

State

Registrar

31. Date filed (Month, Dey, Year)

SEP 3 0 1997



Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 05:25 Elwood ichard Helman ent /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Carnty Hospital Washington Washington
5. Social Security Number) 6 Hagerstown If Under 24 Hrs. 8. Date of E If Under 1 Year 6. Sex 9. Birthplece Stete or Foreign Country) **Funerai** 8. Date of Birth (Month, Day, Year) Months 10€M 2□ F 203-10-9272 Days Hours Director Wzynestoro, Ta Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Expression result be notified at 10d. Inside City Limits 1 Yes 2 No Director tranklin 24nes boro 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA zartield 51 7268 12. Was Decedent Ever in U,S. Armed Forces?

1 27 Yes 2 No If Yes, Give Year or Dates: 444 14. Rece - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ANo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumetic event, the Me Elementery/Secondary (0-12) College (1-4or 5+) 8 achine 10/523906 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Helman Emory aroline prenkle auld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Winifred G. Helman

20a. Method of Disposition

10 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Wzynesboro 20b. Place of Disposition (Name of cemetery, crematory or other place) ra Date 20c. Location - City or Town, State Waynesboro 21. Signeture of Funeral Service Licensee and Address of Facility 6 rove 22. Name Funeral Home, 23a. Part1. Fifer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Fa Wzynesboro 17268 Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final FUNGAL SEPSIS disease or condition resulting in death) Examiner RESPIRATORY FAILURE bunial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of): and physician a the bunal Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. PERIPHERAL VASC DIS: 1 Yes 2 No 3 Probably 4 Unknown REMAL FAILLIRE signed I þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed ATHEROFFIBLIC DEFARE CORSIMAN HEHAT DIG. page 2 s 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpetlent 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28d. Describe how Injury occurred Certification: 28c. Injury at Work? Richard 1 Naturel 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funeral D 12 Certifying Phyeicien: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of cartifie 29c. License number 29d. Date signed (Month, Day, Year) 10.1.4 013712 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) OTTO ROZA HA 12983 DAKHILLAL. HACKUSTUN HO 21742

32. Registrar's Signature

whia Davidson Randalle

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State

Registrar

31. Date filed (Month, Day, Year)

Elwood Helman

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30667 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 06:57 AM MARY ELIZABETH HOLMES Sept /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Sociei Security Numbar If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2√F Months Deys Hours Yrs. Director 217-56-2484 May 10, 1905 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be nothing at Director 1 Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 North Artizin Street 21795 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: by Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Page Tand Should be filed within and Mental Hygiene.

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If you other traumatic event, the Menty or other traumatic event, the Menty or other traumatic event, the Menty or other traumatic event, the Menty or other traumatic event, the Menty or other traumatic event, the Menty or other traumatic event, the Menty or other traumatic event, the Menty or other traumatic event, the Menty or other traumatic event, the Menty of the Menty o Elamantary/Secondary (0-12) 8 Years College (1-4or 5+) Homemaker Personal Residence 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Malden Surname) Be Unknown Catherine Haines Marsh Flook 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Numbar or Rural Routa Numbar, City or Town, State, Zlp Coda) Gladys N. Pacyna, Daughter 17718 Woodcrest Road, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, State 1X Burlal 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 09/29/97 Hagerstown, Maryland 21. Signature of Funerel Service License 22. Name and Address of Facility 7606 Old National Pike P. Steven Danfelt, Jr. BAST FUNERAL HOME Boonsboro

23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Boonsboro, Maryland 21713 Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) CONCESTIVE HEART FAILURE **Examiner** UNKOWN DILATED CARDIOMY OPATH sician and bunal-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or es a consequence of): Physician/Medical the Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by t 1 Yes 25 No 3 Probably 4 Unknown PNEUMONIA py 24b. Were autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performed? SENILITY page 2 2 10 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Invastigation 1 Yes 2 No 2 Accident 6 Could not be datarminad 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral Discompletely filled 1 Cartifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifiar 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Sept 27, 1997 144996 20311 LAPPANS LO BOONSBORD MD 21713 30. Name and address of person who completed cause of death (Item 23a) (Typa, Print) ZAFAR MAUK MD.

32. Ragister's Stratison Randelle

State Registrar 31. Date filed (Month, Day, Year) SEP 2 9 1997

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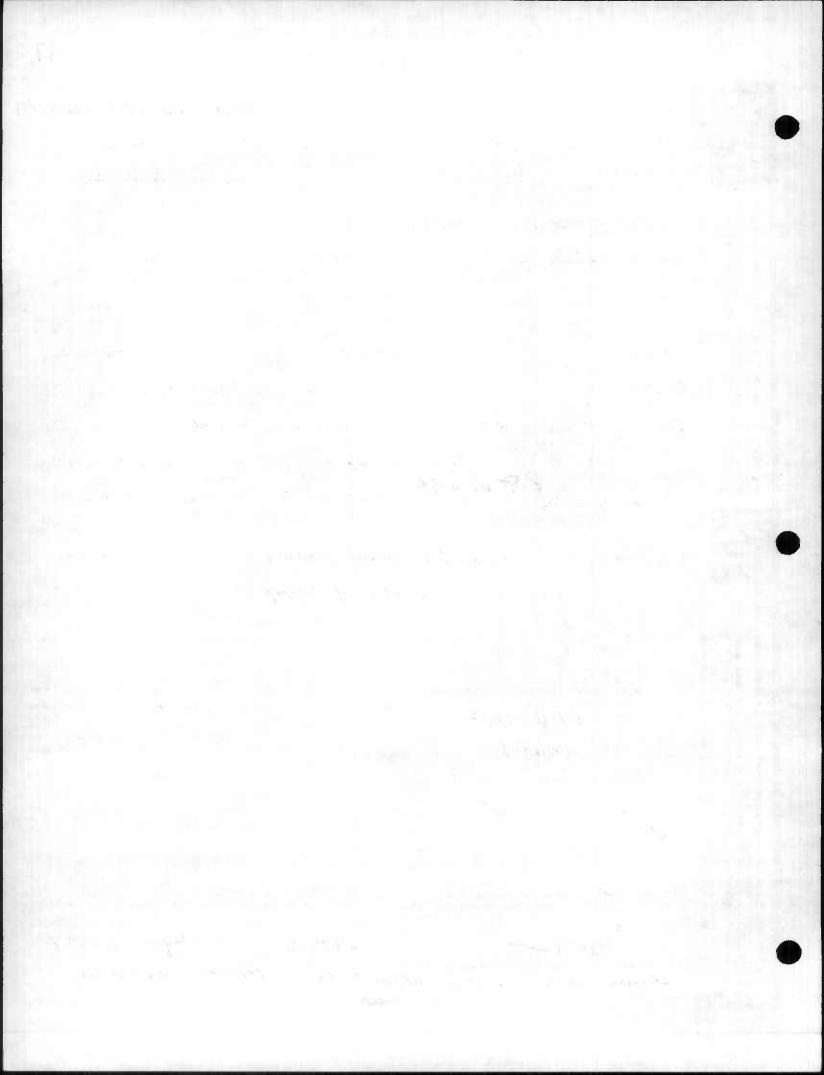
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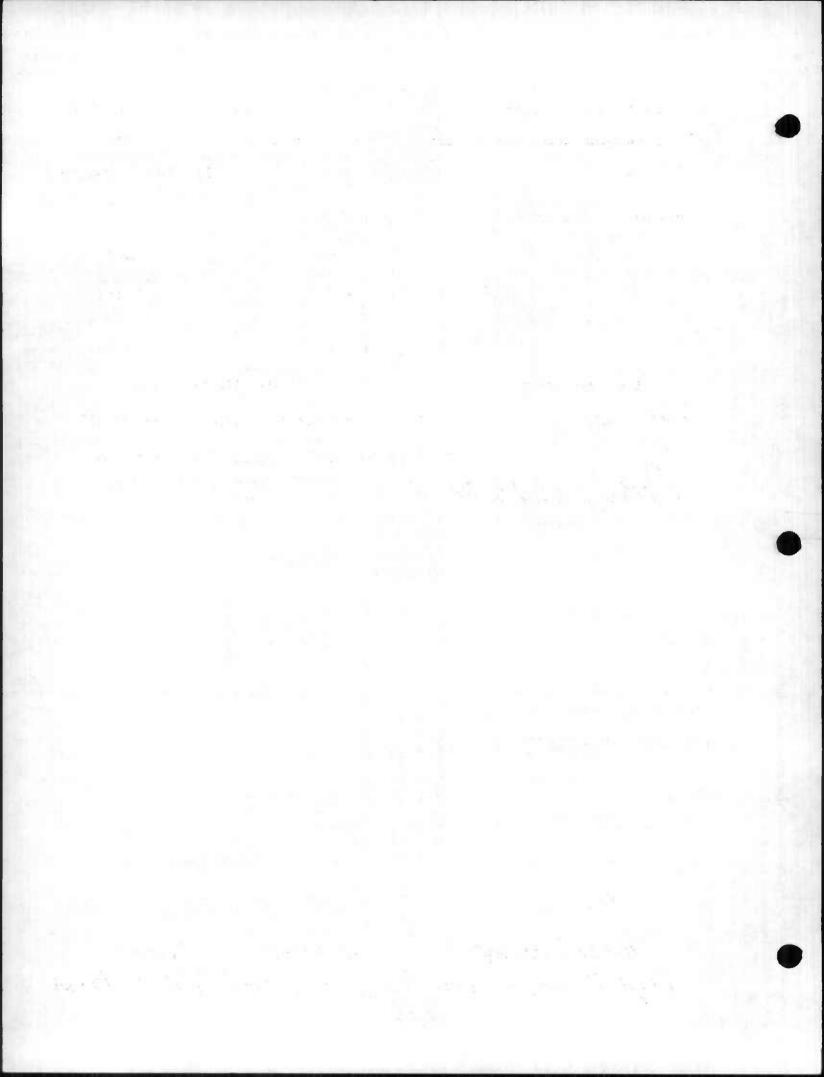


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State of Maryland / Department of Health and Mental Hygiene

30668

					Cei	tificate of	Death			Reg. No.		
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Physic /Med		Doral Leoma	Hoff						Septem	ber 20	1997	12:00PM
Exam		4a. Facility Name (If not institution, g.		nber)			4b. City, To	wn, or Lo	ocation of Death		of Death	
		Northampton Ma	nor Nurs	sing Home	2		Free	derio	ck	Fre	ederic	k
Funera		5. Sociel Security Number 6.	Sax	7. Age (In yrs. last	birthday)	If Undar 1 Yaa			8. Date of Birt	h	9. Birthplac	ca (State or Foraign
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Date of Digital	e I	4 Homicide	buildin	g, etc. (Specify)					City or Tow	n, Stete)		
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		30. Name and address of person who	completed assist	of death (them as	a) /Time !	Drint)		- (		7122	/7 /	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Year GEORGE ALBERT HEINEFIELD 10,1997 11:30AM Sept. 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Parkville Oak Crest Village Baltimore If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **X** 2□ F Days 213-18-4836 73 Yrs. June 9,1924 Maryland Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Parkville 1 ☐ Yes 2 ☐ No. 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd., Apt. #2004 21234 U.S.A. 12. Was Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Nevar Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: 1 ☐ Yas x2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Sacondary (0-12) Collega (1-4or 5+) Real Estate Accountant 18. Mother's Name (First, Middle, Maldan Sumame) 17. Father's Name (First, Middle, Last) Mary Louisa Walters August George Heinefield 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 1 Smeton Place #502; Towson, Md. 21204-2719 Samuel J. Oddo /Adm.Est. 20b. Place of Disposition (Nama of cemetery, crematory or other place) Sept. 12, 1993 tevensville, 20c. Location - City or Town, State 1 ☐ Buria! 2 ☑ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Chesapeake Cremation Center Funeral Service Licensea 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home entheri 106 Shamrock Rd., Chester, Md. 21619 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23 months Due to (or as a consequence of): Due to (or as a consequence of): 23b. Dld tobacco use contribute to the cause of death?

**Physician** /Medicai **Examiner** 

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physician e

signed by 1

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific.

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Physician/Medical

by

Completed

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Certification:

edical

P.O. Box 68760,

Records,

Division of Vital

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show treumetic event, the Medical Examiner must be notified at

d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "na

permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If them 27 is marked othe any injury or other treumetic event.

Baltimore, Maryland 21215-0020

5. Social Security Number

10e. Street and Number

10a State

Md.

12

20a. Mathod of Disposition

Director

Funeral

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Completed

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in daath) Last

4 Homicida

Immediata Cause (Final disease or condition resulting in daath)

Part II. Other significant conditions contributing to death but not resulting in the undarlying ceusa given in Part I.

1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Wara autopsy findings available prior to complation of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner?

1 Yas 2 No 28. Place of Death (Check only ona) Other: 4□ Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 28b Time of 28c. Injury at Work?

27. Manner of Death 28a. Date of Injury (Month, Day Year) 1. Natural 5 Pending invastigation 2 Accidant 6 Could not be detarmined 3 Sulcida

1 Yes 2 No 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Straat and Number or Rural Route Number, City or Town, State)

29s. Certifies

Medical Examiner: On the basis of my knowledge, death occurred at the tima, date and placa, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

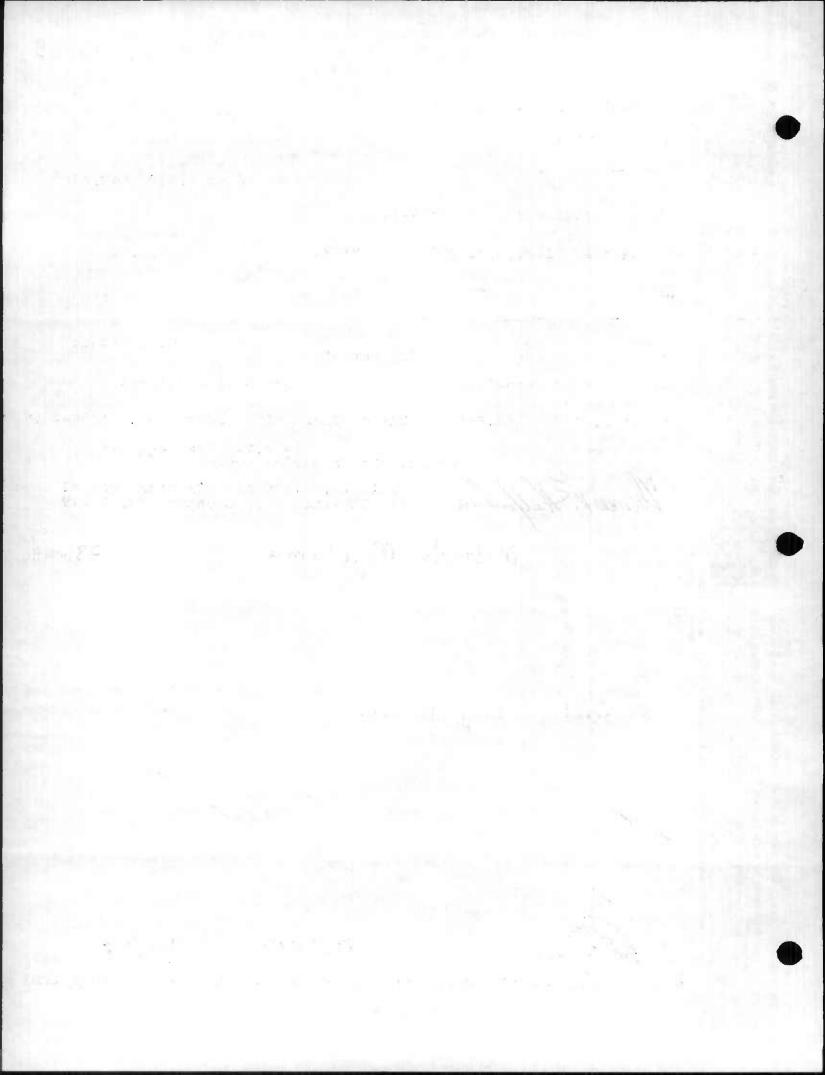
29b. Signature and the office 29c. License number D33847

29d. Date/signed (Wonth, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Charles St 56 Baltimore 4300 MD.

State Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician**

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2. Dete of Deeth		5			3.	Time	e of	Deetl	1
Sent :	27		19	97	C	8	-	12	

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/Medical Examiner

21215-0020 Baltimore Maryland

Richard Harbaugh Isiminger Am 4a. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Washington County Hospital Hagerstown Washington H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Jan. 14, 1921 5. Social Security Number 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign Pennsylvania 7. Age (In yrs. last birthday) **Funeral** 188-18-2926 76 Yrs. Director Usual Residence of Decedent 10e. Sfate 10b. County 10c. City, Town or Location a or 28a-f show 10d. Inside City Limits Director 1 Yes 2 No Kane North Aurora 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Counfry? 301 Long Ave. U.S.A. "natural", or items 23s 60542 Funeral 12. Was Decedenf Ever In U.S. Armed Forces?

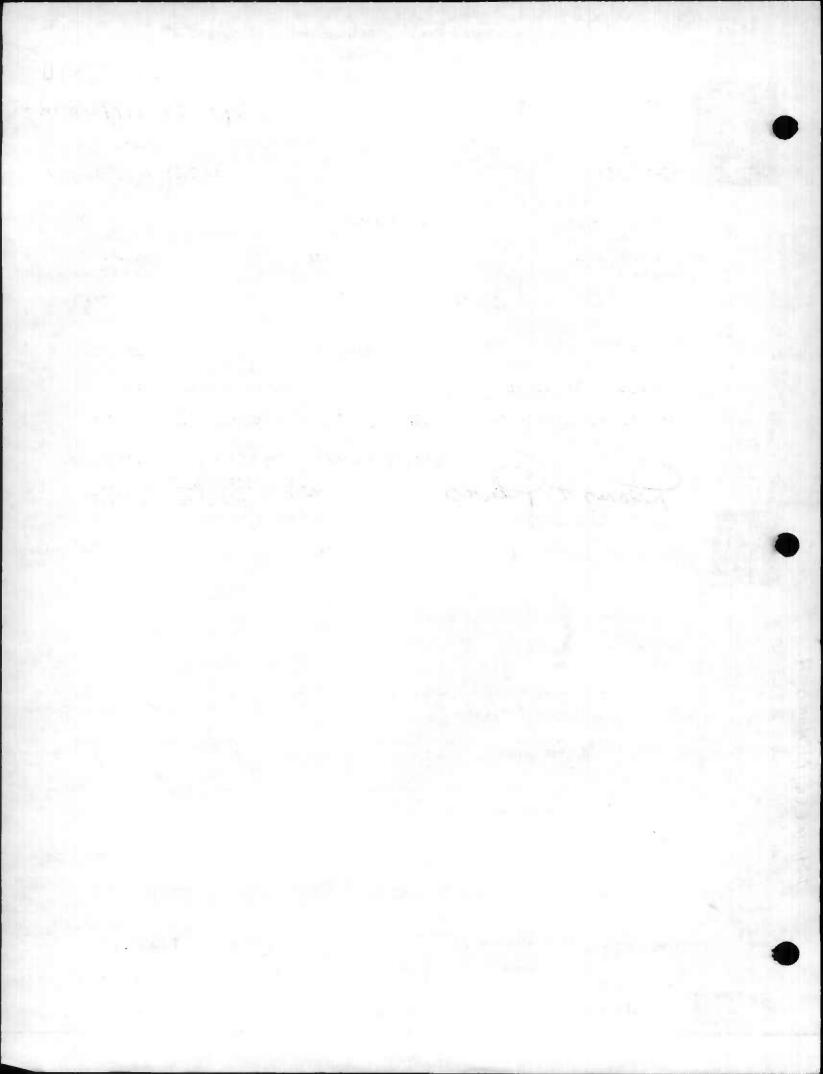
1 ★ Yes 2 □ No If Yes, Give Year or Dates: 41 - 45 Race - American Indian, Black, White, etc. 11. Marifel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) d 2 should be filed within 72 hours effer the and Mental Hygiene.
?? Is marked other than "natural, or itel traumatic event, or Medical Examinat 1 Never Married 2 Merried 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Supervisor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth jury or other traumatic even Be William L. Isiminger Hazel Harbaugh 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 301 Long Ave. North Aurora, Illinois Janet A. Isiminger (wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Smithsburg Crematory Sept. 28, 1997 Smithsburg, Md. 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Ternes Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset end Death **Physician** Bram Slem /Medical Immediate Cause (Final 48 Hours diseese or condition resulting in deeth) **Examiner** Due to (or es a consequence of) Examiner Res ician and buriei-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Physician/Medical the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? mellitus Diahetes 1 Yes 2 No 3 Probably 4 Unknown signed I by Aspiration 24b. Were autopsy findings evallable prior to Completed 24e. Wes en eutopsy performed? completion of ceuse of deeth? 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No of Vital director, Be 25. Was case referred to medical 26. Piece of Death (Check only one) Hospital: 1 Inpatienf 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To this funerai 28e. Defe of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury af Work? 28d. Describe how injury occurred After or Attending 1 Watural 5 Pending Investigation 1 Yes 2 No death. 2 Accident efter death 8 Could not be determined 3 Suicide 28f. Locaflon (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours e To the Funeral E completely filled Hospital 1 Certifying Phyatcien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner es stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medical ş 29b. Signeture and title of certifiey 29c. License number 29d. Dete signed (Month, Day, Year) The and title of certified ham, mo 9/28/97 022136 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 11110 medical Campon Drive. Hagenlown, MD2174 MEHRULLAH KITAN Suite 227 31. Date filed (Month, Day, Year) 32. pegistrer's Signature
The Davidson-Randelle

State

Registrar

SEP 2 9 1997

ESIMINGER, ACHARD



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THE PERSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 24A Per Phy Film G-755 1-22-98RC Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physiclan** Month Sept 1997 3:45P Raymond William Jordan, Sr. /Medical 4b. City. Town, or Location of Death 4a. Facility Nema (If not institution, giva street and number) 4c. County of Death **Examiner** The Memorial Hospital Talbot Easton 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 6 Sax 8. Data of Birth (Month, Day, Yaer) Birthplaca (Stata or Foreign Country) **Funeral** 1₩ M 2□ F Days Yrs. Director 220-03-5899 Usuai Residence of Decedan 76 07 - 13 - 21Scotland the Maryland 10e Steta 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatte evant, its Mandes Examine must be notified at 10d. Insida City Limits 1 Yas 2 No Director MD Caroline Denton 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 25374 Harpers Branch Drive 21629 U.S.A. Funeral Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Americen indian, Black, Whita, atc. 12. Was Decadant Evar in U,S. Armad Forcas? 1 GYas 2 No If Yes, Giva Yaar or Dates: 1945-46 1 Nevar Married 3 Married Raymond Jordan Baltimore, Maryland 21215-0020 Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Dacadant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry (welder) Elamantary/Secondary (0-12) Coilega (1-4or 5+) Maintanance Welder Proctor & Gamble 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 20 Hanah Walters William Jordan 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, State, Zip Coda) 19a. informent's Name/Ralationship (Type, Print) 25374 Harpers Branch Dr. Denton, MD 21629 Dorothy Jordan Wife 20b. Place of Disposition (Nama of camatary, cramatory or other piece) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Buriel 2 □ Cramation 3 □ Removel from Stata 4 □ Donation 5 □ Othar (Specify) Woodlawn Memorial Park 9/27 Easton, MD 22. Name and Address of Fecility Fellows, Helfenbein, & Newnam 21. Signature of Funaral Service Licensaa Funeral Home 408 S. Liberty CentrevilleMD 23a. Part1. Enter the disaasa, or complications that ceusad the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Intervei Between Onsat and Death Physician /Medical Immadiata Causa (Final disaesa or condition resulting in death) noschenotie coronaz vasula decar los Examiner Dua to (or as a consequence of): burial-transi Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Ceuse (Diseasa or Injury that Initiated avants resulting In daath) Last pue Dua to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of) Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ 100 3 □ Probably 4 □ Unknown Records. by 24e. Was an autopsy performed? 24b. Wera autopsy findings eveilable prior to completion of cause of daath? Completed arxbrobascular acciden 1 ☐ Yas 2 KNO 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was casa referred to medical axaminar? Be 26. Placa of Death (Chack only ona) Hospital: 1 papatiant 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1 Yas 2 No 28a. Dete of injury (Month, Dey Year) 27. Menner of Death 28b. Time of Certification: 28c. injury at Work? 28d. Describe how injury occurred 1 Returel 5 Panding 2 Accidant 1 ☐ Yes 2 ☐ No invastigation 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of injury - At homa, farm, streat, factory, office building, atc. (Spacify) 5 4 Homicida Certifying Physician: To the best of my knowladga, daath occurred at tha tima, date and placa, and dua to tha causa(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) Medical 29a. Certifier and mannar statad. 29b. Signature and talls of certifies 29c. Licansa numbar 29d. Date signed (Monfh, Day, Year)

State Registrar

31. Deta filed (Month, Day, Year)

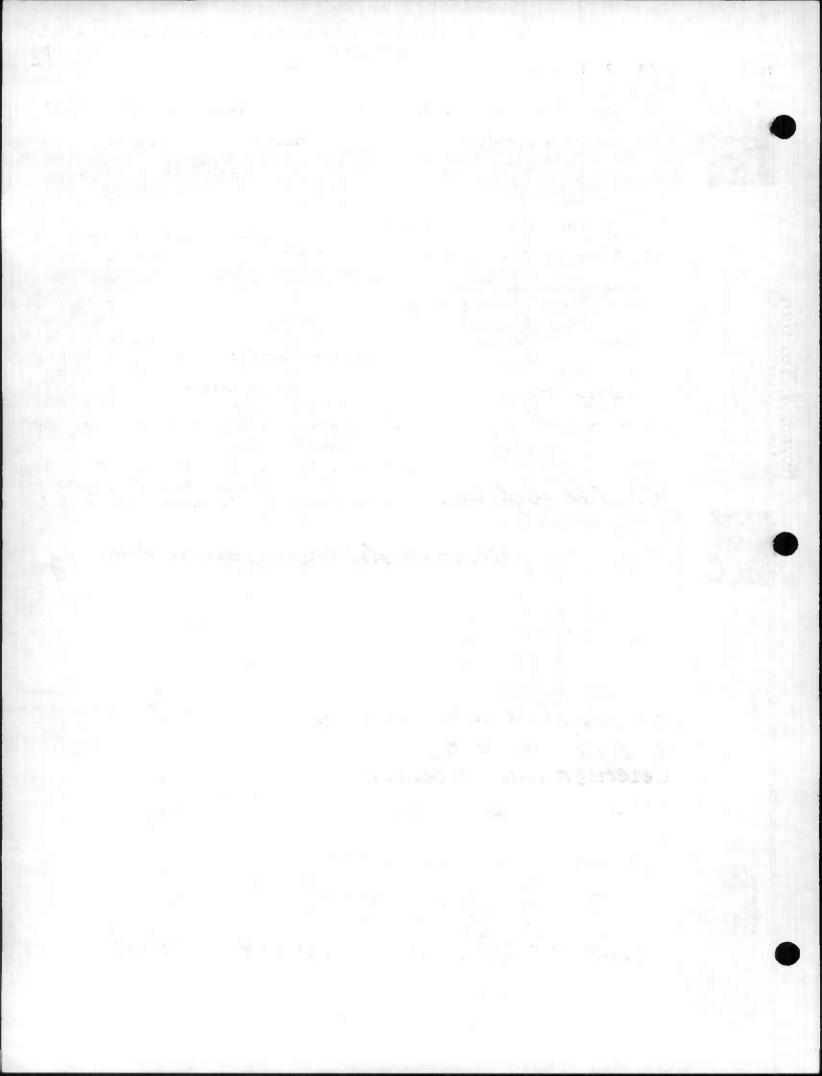
30. Name and address of parson who completed causa of death (itam 23a) (Type, Print)

Memorial Hospital at Easton P.O. Box 496

Denton, MD

21629

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 30673 Certificate of Death 2. Date of Deeth 3. Time of Deeth Month Se stomer 29 1410

10d. Inside City Limits

21782

Approximete Intervel Between Onset end Death

4 years

1 Ves 2□No

**Physician** /Medical Examiner

Director

Funeral

Completed by

Be

Examiner

Physician/Medicai

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Completed

Be

Certification: To

Medicai

1. Decedent's Neme (First, Middle, Last)

**Funeral** 

Director "natural", or items 23a or 28a-f show death 72 hours efter permit. Pages 1 and 2 should be filed within 72 ht. Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natur any injury or other traumatic event, the Medical page.

21215-0020

Baltimore, Maryland

**Physician** /Medical Examiner

ician end buriel-transit physician s the buriel P.O. Box 68760, 98 ate has been signe pege 2 should be ain Frances Arity this certificate or Attending Physician: funeral director, After efter death. within 24 hours effer der To the Funeral Director completely filled in by the Hospital

Frances Anita Karn 4b. City, Town, or Location of Death 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Deys 10 M 20 F 76 214-16-0557 Yrs June 20, 1921 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1747 Edgewood Hill Circle Apt. 101 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) operator C & P Telephone Co. 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Charles Howard Nigh Martha E. Delauter 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Sharpsburg, Terry E. Karn Son 4105 Mills Road Maryland 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 ☑ Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Rose Hill Cemetery 10/2/97 | Hagerstown, Maryland Signature of Funeral Service Licensee 22. Name end Address of Facility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart faiture. List only one cause on each line. Immediete Ceuse (Finat Overien diseese or condition resulting in death) Due to (or es e consequence of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequenca of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were eutopsy findings evaltable prior to completion of cause of deeth? 24a. Wes en eutopsy

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 SNaturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and ptace, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer)

041667

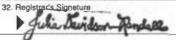
medend MA 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

11110 Medical Congus Rd. Hosestown, MD. 21742

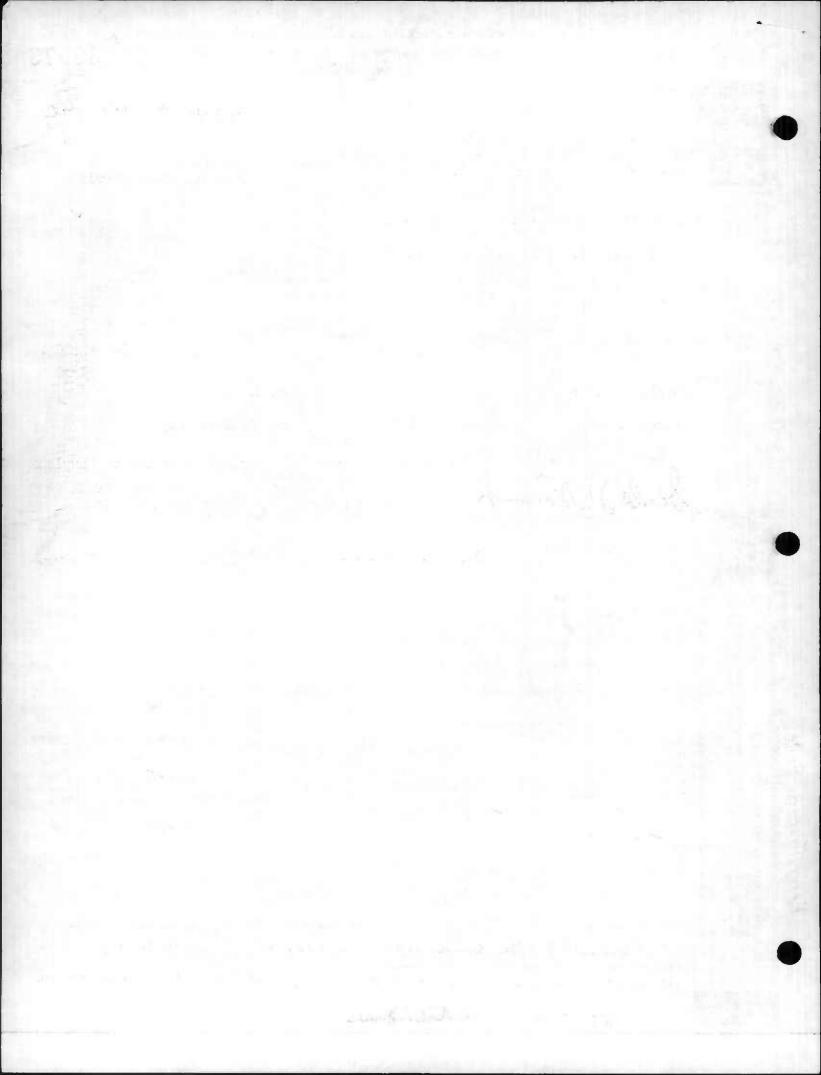
9.30.97

State Registrar 31. Dete filed (Month, Day, Year)

Michael J. McCornek



To the



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30674 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 3. Time of Death September 29 DOUGLAS THEODORE KINCADE 1997 11:00pm 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Physicians Memorial Hospital LaPlata Charles 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) M 2□ F 579-01-1253 79 MAY 14,1918 WASHINGTON, D. Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ➡ No MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8770 BENSVILLE ROAD U.S.A. 20603 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1942 — Yaar or Dates: 1945 AMERICAN Specify: INDIAN 1 Yes 2 No Specify: 3 Widowed 4 Divorced 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) GEM ELECTRIC CO. TRUCK DRIVER 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) OSCAR BACH LILLIAN BACH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) BARBARA MARKLEY-DAUGHTER 20 ALLEN DRIVE HANOVER, PA. 17331 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VET.CEMETERY10-3-97 CHELTENHAM, MARYLAND 21. Signatura of Funeral Service Licansee 22. Nama and Address of Facility RAYMOND FUNERAL SERVICE LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory erresponds, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) Brondo - Alucolar OBSTRUCTIVE PULMONARY MAM YRS CHRONIC Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequanca of) 23b. Did tobacco use contributa to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown SEIZURE DISORDE 24b. Were autopsy findings aveilable prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

90

P.O.

Division of Vital

item 27

b

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

must be notified at

Director

Funeral

by

Completed

Be

Examiner Physician/Medical by Completed Be To To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funera Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Invastigation 1 Matural 1 Yes 2 No 2 Accident

6 Could not be determined 3 Sulcide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. (Check only one) 29b. Signature and title of cartifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

OCT 01

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Niran Sharma, MD 11345 Pembrooke Square, Suite 104, Waldorf, Maryland 20603 31. Date filed (Month, Dey, Year)

State Registrar

Medical

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Day George Robert Kerr September 26,1997 2:50AM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ft. Washington Profile If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 11501 Old Fort Road Prince George's 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Months 1 M 2 □ F 72 Yrs. Director 578-20-9852 Usual Rasidanca of Dacedani April 11,1925 North Carolina 10a Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits traumatic event, the Medical Examiner must be notified at Maryland Prince George's Directo Ft. Washington 1 ☐ Yas 2X No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6 11501 Old Fort Road 20744 U.S.A. Items 23a Funeral death 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puanto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. filed within 72 hours after 1 Navar Marriad 2 Married Yas 2 □ No f Yas, Giva 21215-0020 ò 1 Yas 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratirad) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry nd Mental Hygiana. marked other than Elementery/Secondary (0-12) N/A (1-4or 5+) Yard Conductor Rail Road Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Hgakh and Mental Hy Important: If them 27 is marked othe any Injury or other traumatic event any Injury or other traumatic event ance. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Sumama) Be Worth Kerr Laura Pink Sloot 2 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Scott Kerr (SON) 3821 Pearl Street, White Plains, Maryland 20695 20b. Placa of Disposition (Nama of camatary, cramatory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Surlal 2 ☐ Cramation 3 ☐ Ramoval from State Maryland State Veterans Cem Cheltenham, MD Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD20735 ant. Entar tha disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immadiata Causa (Final Diostote 3 years Cance diseese or condition rasulting in daath) Examiner Dua to (or as a consequence of): The law requires that the death certificate be executed Sequantially list conditions, if eny, leading to immediata cause. Entar Underlying Causa (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Box 68760, physician Physician/Medical Dua to (or as a consequance of): datached Records, P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown signed b by been si Be Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of daeth? irector, paga 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: director, 25. Was casa rafarrad to medical 26. Pteca of Death (Chack only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 10 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this 28e. Data of Injury (Month, Day Year) 27. Mennar of Deeth Certification: 28b. Tima of Injury 28d. Dascribe how Injury occurred 28c. Injury at Work? Aftar 5 Panding Invastigation 1 Netural death. 1 ☐ Yas 2 ☐ No I Director: A 2 Accident 6 Could not be datarmined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homleida filled in Hospital 24 hours 15 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

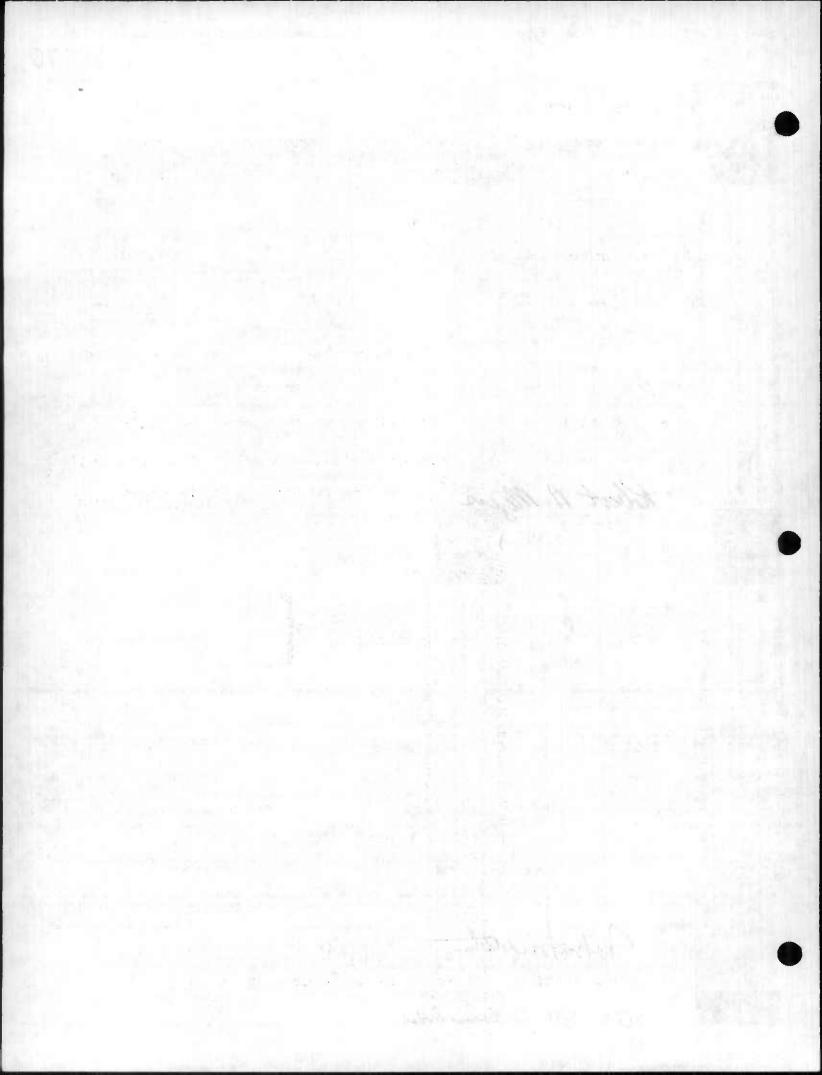
2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Year) D35206 26 57 30. Name and eddress of person who complated causa of death (Itam 23a) (Type, Print) William T. Tanner M.D. 11701 Livingston Road # 101 Ft. Washington MD 20744 31. Data filad (Month, Day, Year) SEP 3 0 1997 32. Ragistrar's Signetura State Registra

State of Maryland / Department of Health and Mental Hygiene

30676 Certificate of Death 2. Date of Death 3. Time of Death

DHMH 16 Rev 6/95

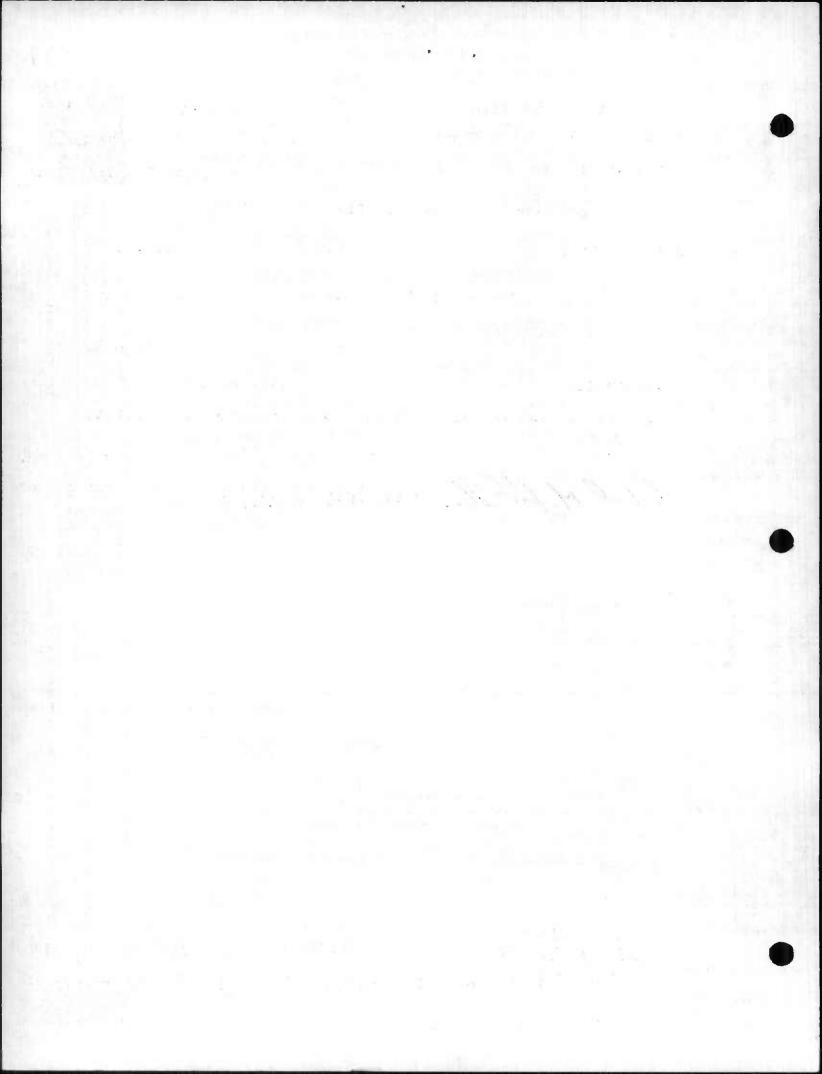
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fand	MON W		10a. State 10b. County		10c. City, Tov	vn or Location						10d. inside City Limits
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	n nem 27 is marke or other traumatic		20a. Method of Disposition 1 □ Purial 2 □ Cremation 3 □	Removal from State	20b. Place o	of Disposition (Nar ory, crematory or o	me of other plac	a)	Data	20c. Location	n - City or T	Town, State
P Pa	jury		4 ☐ Donation 5 ☐ Other (Specify	y)	Everg	reen Mem			s 9/27	Finksb	urg,	Maryland
permit. Page Department of	any in		21. Signature of Funeral Sarvice Licen	see 7		22. Nama an			01 **!*			
0.03	400		Tobert A	Muer	2			al Home	Westmi	lis Str	eet MD 2	1157
		5	23a. Part1. Enter the disease, or comp shock, or haart tailure. List only	olications that caused one cause on each lin	tha death. Do	not enter the mod	de of dyln	g, such as cerdia	ac or respiratory	errest,		Approximete interval Between
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after death	by the	fica	3 Suicide 6 ☐ Could not be		/rv - At home, fa	ırm, street, factory		TO LENO	28f. Location (	Street and Nun	n <i>ber</i> or Ru	ral Route Number.
a after	ui þe	Certification:	4 Homicide	building, etc.	. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,			wn, Stata)		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	completely filled	edical	29a. Certifier 1☑ Certifying Phy (Check only one) 2☑ Madical Exam	eiclan: To the best of her: On the basis of and manner stat	t my knowledge examination an ted.	e, death occurred a d/or investigation,	at the tim , In my or	e, date and place Inion, death occ	e, and due to the urred at the time,	ceuse(s) and r date and plece	nanner as	steted. to the cause(s)
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			30. Name and add ses of person who o	completed ceuse of de	eath (Item 23e)					J 43.		
			John W. Middleton	M.D. 688	8 Poole	Road, We	estm	inster,	MD 211	57		
	Stat	i.e	31. Date tiled (Month, Day, Year)		r's Signature							
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ai', or itema 23a or 28a-f ahow Examiner must be notified at	by Funeral	11. Maritai Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	Armed Force	ant Evar in U,S. as? 1953- as:	13. Y	Was Deced If Yas, special 1 Yas		Ispanic Ori an, Maxicar Specify:		ecify Yas or No Rican, atc.)		lace - Ama liack, White city: Wh	
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9 5 6		19a. Informant's Name/Raiationship Mrs. Mary J.			19b. Mailir 501	ng Addrass Kent	(Street	and Number	eror Run	al Routa Numb ensvi	per, City or Tow	vn, Stata, 2 Id • 21	Zip Code) 666
Important: If item 27 any injury or other tr		20a. Mathod of Disposition		20b. Piace	e of Dispo	sition (Na	na of			Date 7	20g Locatio	n - City or	Town, Stata
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important-If any injury or once.		21. Signatura W Funeral Service Lic		7 71	22	2. Nama ar	nd Addras	ss of Facilit	ty				
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DHMH 16 Rev 6/95



Helen C. Lenhart BALTIMORE, MABYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

SJICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 mm as a minuted by me hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral directing and directing the state of the tast as the burial-transit permit. Pages 1, 2, 3 should	h the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	id, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed to	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and com-	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, c	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic ev

Vasant Datta 3
31. DATE FILED (Month, Dey, Year)
SEP 2 6 1997

334 Mill St. Hage
32. REGISTRAR'S SIGNATURE

Julia Mudler Reveal

FOR 1 - STATE REGISTRAR	STATE OF MARY		TMENT OF I		MENTAL HYGIEN	E	, ,	306/6
t. DECEDENT'S NAME (First, Middle, Last)		OLITIII	IOAIL OI	DEATH	2. DATE OF DEATN		2 70	ME OF DEATH
Helen Virgi	nia Lenhar	t			September		EAR	
4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH		BIRTNPLACE	(State or Foreign
219-20-4218 9a. FACILITY NAME (If not institution, give s	1 M 2 K F	91 YRS.	MONTHS DAYS	HOURS MIN.	June 2, 19		Mary OF DEATH	land
Fahrney-Keedy Ho				onsboro	EAIN		shing	ton
RESIDENCE OF DECEDENT  10e. STATE 10b. COUNT	Y	10c CITY	Y, TOWN OR LOCA	TION			104	INSIDE CITY
Maryland Was	shington	10%	Boons	boro				VES 2 X NO
100. STREET AND NUMBER 8507 Maplevill	e Rd.		10	21713-18	344	10g. CITIZE	U.S.	
t1. MARITAL STATUS  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 X NO	If yes, sp		NIC ORIGIN? (Specify Yea an, Puerto Rican, atc.)	s or No— 14	Specify: W	nerican Indian, a, atc. nite
ts. DECEDENT'S EDU	CATION	16a, DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BU	SINESS/INDUS		
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of ville. Do NOT us	,	ost of working	Pub	lic Sc	hoo1	
17. FATHER'S NAME (First, Middle, Last) George D. Catlet	t			1	AME (First, Middle, Malden y Pearl Hu	Sumame)		
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, City or Tow	n, State, Zip Co	ode)	
Ernest Koogle/ n	ephew	717 Ir	ndian Hi	11 Dr.	Port Oran	ge, FI	3211	9
20e. METNOD OF DISPOSITION 1 (X) Burlel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	noval from State 20	Db. PLACE AND DATE Of the complete of the comp	OF DISPOSITION (N	ame of		CATION — CIT	y or Town, Si	
et affarin	e O.Da	Dlev	22. NAME A	ND ADDRESS OF FA		r Fune		ome
23. PART I. Enter the diseasea, or shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on	of the deeth. Do rasch lina.			ch sa cardiac or reap	iratory srres	t,	Approximate interval Between Onset and Death
Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	b DUE TO (OR AS	A CONSEQUENCE OF	F):					y
PART II. Other significant conditions  Party dratus Party Candrawa Calons	ns contributing to death	but not resulting	in the underlying	ng cause given in	Part I. 24a. WAS AMPERFO	RMED?	AVAIL COM OF D	AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH?
DID TOBACCO USE CONT					N IS		1	YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA						
1 ☐ YES 2 € 110	1 D Inpatient 2 D ER/Ou		4 Nursing No	me 5 🗆 Residence	8 Other (Specify)			
27. MANNER OF DEATH  1	28a. DATE OF INJURY (Month, Day, Year)		JURY W	JURY AT ORK? YES 2 NO	26d. DESCRIBE HOW	INJURY OCCU	RED	
3 Suicide 6 Could not be 4 Nomicide detarmined	26a. PLACE OF INJUI building, atc. (Sp	RY — At home, farm, secify)	atreat, lactory, offi	ca	281. LOCATION (Street City or Yown, State		Rural Route I	Vumber,
(Singer Sing	SICIAN: To the best of my kno							menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIE	ER EXECUTED		-	29c. LICENSE NU			BIGNED (Mon	th, Day, Year)
30. NAME AND ADDRESS OF PERSON W	-	DEATN (ITEM 27) (Type	, Print)		• •	, = 1		

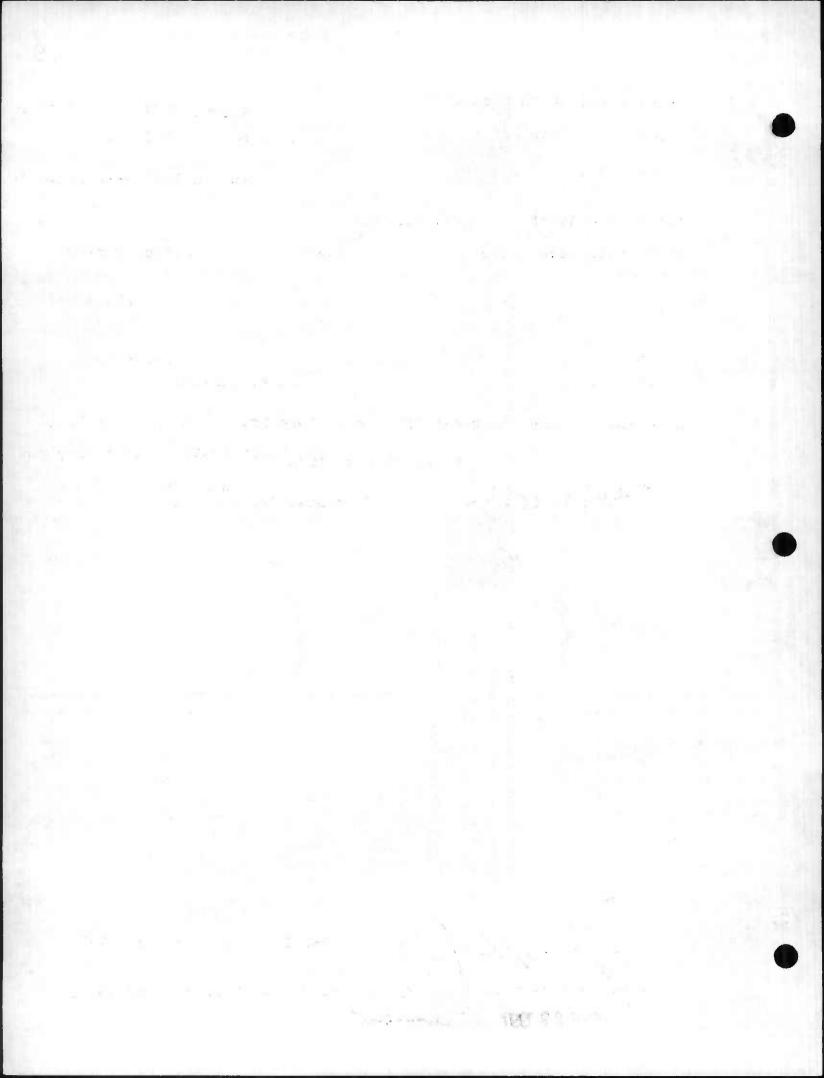
Hagerstown, MD 21740

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9.7

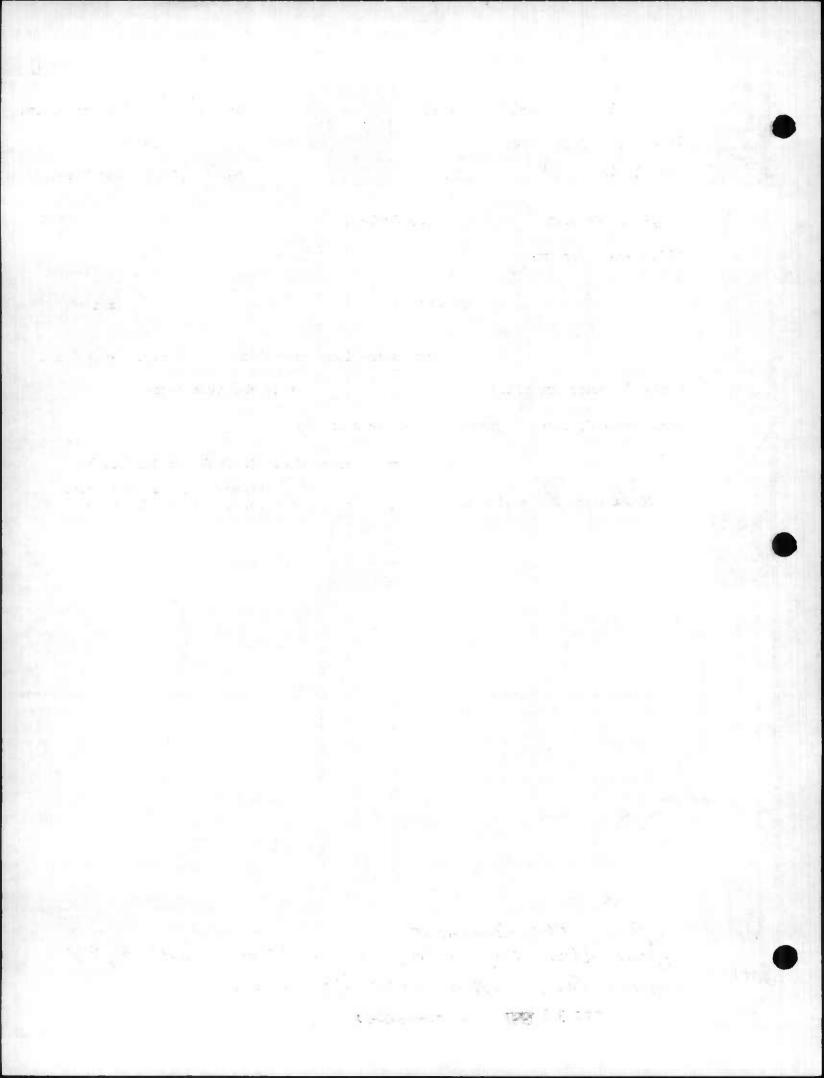
30679

					,,	Certificate of		, violitai i i j	Reg. No.	1 00013
	Physic	ian	1. Decedent's Name (First, Middla, La Violet Elizab	eth Leon	ard	144		2. Dete of Dea	ath Day	3. Time of Death
	/Medi Exami	ical	4a. Facility Nama (If not Institution, gh 5521 Wells Co				4b. City, Town, or St. Le	September Location of Deeth onard		
	Funeral Director		579 07 2194	Sax 7. Ag 1□M 2√2 F	ga (In yrs. last bi 87	rthday) If Under 1 Yaa Months Day:			h, Year)	9. Birthplaca (State or Foreign Country) Washington D
	and w		Usuel Residence of Decedant  10a. Stata 10b. County		10c. City, Toy	vn or Location				10d. Inside City Limits
	Mary Fired	tor	Maryland Calve	rt	St. I	eonard				1 ☐ Yas 2 🔀 No
	ith with the Marylan 23s or 28s-f show ust be notified at	ai Director	10e. Street end Number 5521 Wells Cov	e Drive		10f. Zip Code 2 0	685		10g. Citizen of W United	That Country? States
21215-0020	or items	by Funeral	11. Meritei Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Wes Decedant Armed Forcas? 1 Yes 2 If If Yes, Give Yaar or Detes:		13. Wes Decedent of If Yas, specify Cu		Specify Yas or No- rto Rican, etc.)		- American Indien, K, White, etc. White
5-0	"natural",	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a	Decedent's Usuel Occi (Give kind of work don- iife. DO NOT usa retir	upetion e during most of wo	orking	16b. Kind of Bu	siness/industry
121	iene.	mpi	Elementery/Secondery (0-12)	College (1-4or	5+)					
land 2	be filed htal Hygi of other event, I	To Be Co	8 17. Father's Name (First, Middia, Last George Parker	)		housewife	18. Mother's Na	me (First, Middle, y Rolli	Meiden Sumeme	home
, Maryland	52 should and 7 is mutaum	-	19e. Intorment's Neme/Reletionship (	* 1		o. Meiling Address (Street				
Baltimore,			20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		20b. Plece camere Parkl	of Disposition (Name of ary, cremetory or other pi awn Mem.	Sept.	29 1997	20c. Location - ( Rockvi	City or Town, Stata lle Maryland
Balt	permit. Pages Department of important: If is any injury or once.		21. Signeture of Funerel Sarvice Licer	usch		22. Nama and Addi	C- 1011			l HOme PA public MD
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or com shock, or heart feilure. List only Immediate Cause (Finel disease or condition resulting in death)			TNFAR consequence of):		c or respiretory er	rest,	Approximate) 676 Interval Between Onset end Deeth
	pet nsit	Examiner		b. CORUM	my 1	ARTERY D	UENSE			YEARS
68760,	tificate be executed g physician and as the bunal-transit		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	C		consequence ot):				
Box 68	# 00.00	n/Medicai	resulting in death) Last	d	Due to (or as a	consequence ot):				
.0	death ce ne attendir ed for use	sicia	Pert II. Other significant conditions of	ontributing to death b	ut not resulting i	n the underlying cause g	iven in Pert I.	23b. Dld t	obacco use con	tribute to the cause of death?
s, P.O.	requires that the death cer been signed by the attendir should be detached for use	by Phy	CONGESTIVE THE	DRT FA	LURF	-		101	fes 2□ No	3 □ Probably 4 Unknown
Records,	N S S	Completed by Physician/N	ORGANIC BRATE	~ 57~ DR	ME			24a. Wes	an autopsy med?	24b. Were autopsy tindings evallable prior to completion of cause of deeth?
<u>=</u>	The ate h	Con						1 D Y	es 2500	1 🗆 Yes 2 🗆 No
Ĭ,	Physician: The this certificate ral director, pag	Be	25. Wes case reterred to medical examiner?	Hospital:			thor	ath (Check only o		
of Vital	£ 5 5	- To	1 ☐ Yas 2 ☐ No  27. Menner of Deeth	1 ☐ Inpatie		Ithatient 3L DOA	4 □ Nursing r	Homa 5 Resid	ence 6 Othe	
Division	Attending Phy or death. ector: After thi by the funeral of	cation	Netural 5 Pending 2 Accident invastigation 3 Suicide 6 Could not b	(Month, De	Year)	Injury W	ork? ☐Yes 2☐No			
DIX	s after d il Direct ed in by	Certification:	4 Homicide determined	28e. Piece of Injuding, etc.		arm, street, fectory, office		28f. Location (S City or Tow	itreet and Numbern, Stete)	er or Rurai Route Number,
5	To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29e. Certifier (Check only one) 2	ysician: To the best of niner: On the basis of end menner ste	exemination en	e, deeth occurred at the ind/or invastigation, in my	time, dete end plece opinion, deeth occu	e, end due to the d urred at the time, d	cause(s) end mai dete end plece, a	nner as stated. nd due to the cause(s)
	with To E	2	29b. Signature and title of certifier	Akg	1-	D	26358		Sept 2	(Month, Day, Year) 7 1997
			30. Name and address of purson who John H. Weige			(Type, Print) spital Rd	Prince	e Fredo	rick M	D 20679
	Sta Registr		31. Deta tiled (Month, Dey, Year) SEP 2	32. Registre	ers Signeture	ear Rorball		- I LEUE		200/0



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

-		Decedant'a Nama (First, Middle, La.	st)		Certificate of	Death	2. Date of De		30680 3. Time of Death
Physici		CECIL	DAVID I	UCAS			Month	ber 27,1	997 8:40 p.m
/Medic Examir		4a. Facility Neme (If not institution, give				4b. City, Town, or L			
LAGIIII		1136 Lake Ridge	Drive			Sunderla	nd	Calve	rt
Funeral Director		5. Social Security Number 6. S 232 68 6475		(In yrs. lest birth	Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da		9. Birthplace (Stete or Foraign Country) West Virginia
land ow		Usual Rasidanca of Decedant 10a. Stata 10b. County	1	10c. City, Town	or Location				10d. Inside City Limits
Mary a-f sh	tor	Maryland Calvert		Su	nderland				1 ☐ Yas 2 🎇 No
A the	i e	10e. Straat and Number			10f. Zip Coda			10g. Citizan of W	hat Country?
23a c	ralD	1136 Lake Ridge I	rive			20689		USA	
in 72 hours after death with the Maryland shatural, or flems 23a or 28a-f show legical Examiner must be notified at	by Funeral Director	11. Meritel Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Wes Dacedent Ev Armed Forces? 1 X Yes 2 □ No If Yas, Giva Yaer or Datas: 1		13. Wes Decedant of If Yes, specify Cut 1 ☐ Yas 2 ☒ No		pecify Yes or No Rican, etc.)	14. Rece Black Specify:	- American Indian, , Whita, etc. white
C . C	Completed	15. Decedant's Ec (Specify only highast gra Elamantary/Secondery (0-12)	lucation	16a. (	Decedant's Usual Occu Giva kind of work dona lifa. DO NOT use retire	petion during most of worked)	king	16b. Kind of Bus	
202	00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3		munication	s special:	ist	USAF, F	ederal Govt.
be filed withintal Hygiene. Indeed other than event, the Manage of the than event, the Manage of the	Be	17. Fathar's Name (First, Middle, Last)						Maiden Sumame	)
Mer Mer	To	Cecil Clarence Br				Carrie			
sh and resum		19a. Informant's Name/Ralationship (			Mailing Addrass (Stree		ral Routa Numbi	er, City or Town, S	itate, Zip Code)
Ter. 20, 198, 54		Mrs. Ethel S. Luc  20e. Method of Disposition	as / spous		me as # 10		Data	20c Location - C	City or Town, Stata
sermit. Pages 1 a Department of He moortant: If Hem iny Injury or othe 20cs.		1  Burlai 2  Cramation 3  ☐ 4  Donation 5  Othar (Specifi			Disposition (Nama of crametory or other ple ton Nation		10-3-97		ton, VA
Depart Depart Import any in		21. Signeture of Funarai Sarvice Lican	. Those		22. Neme end Addr	R			ome, P.A.
		23a. Part1. Enter tha disaasa, or comp shock, or haart feilura. List only	plications that caused th	na daath. Do no	ot enter the mode of dy	ing, such as cardiac	or raspiratory a	rast,	Approximate Interval Batween
Physician /Medical Examiner	niner	Immediate Ceusa (Final disaase or condition resulting in daath)	a. Sma	// Ce	// Lyn	ig CA.	ncer		9 Mon Th
ficate be executed physician and as the bural-fransit	al Examiner	Sequantially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disaasa or injury	D.	ua to (or as a co	nsequance of):				
* D d	n/Medical	that initiated evants rasulting in death) Last	<b>d</b>	ie to (or es e co	nsequence of):				1
death cert e attendin ed for use	Icla	Port II Other elemitionat conditions of	entribustion to double bust.			Las Is Dan I	One Did	lahasaa waa aast	ribute to the cause of death'
that the ed by th detache	/ Physician/M	Pert II. Other significant conditions of	ntributing to beath but i	not rasulting in	na undanying causa g	van in Part I.	1)		3 Probably 4 Unknow
aw requi	Completed by					N. S.		an autopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
0 - 5	MO.						10	as 2 No	1 Yas 2 No
ician: The	Be	25. Wes casa refarred to medical exeminar?				26. Placa of Deel	th (Check only o	ne)	
Phys ral di	10	1 Yas 2 No  27. Mennar of Death 1/O Natural 5 Panding	Hospital: 1 Inpatient  28a. Deta of Injury (Month, Day Y	28b. Tir	na of ury Wo	ry et ork?	-	dance 8 Other	
Attender deatlector:	ertification:	Accident Investigation  3 Suicide 6 Could not be datamined	-		M 1	]Yas 2□No	28f. Location (S City or Tox		r or Rural Route Number,
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within 2 To the comple	Me	29b. Signature and two of certifier	izf Hems	-Onc	29c. Licen	se number		29d. Deta signed	(Month, Dey, Year)
	Î	Mark Tilla	Imo C	21 m	c. D3	344	6	Sept.	30,97
20+1		30. Nama end addrass of person who of	omplated causa of deal	th (Itam 23a) (T	ype, Print)	2030	27		) -
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State of Maryland / Department of Health and Mental Hygiene

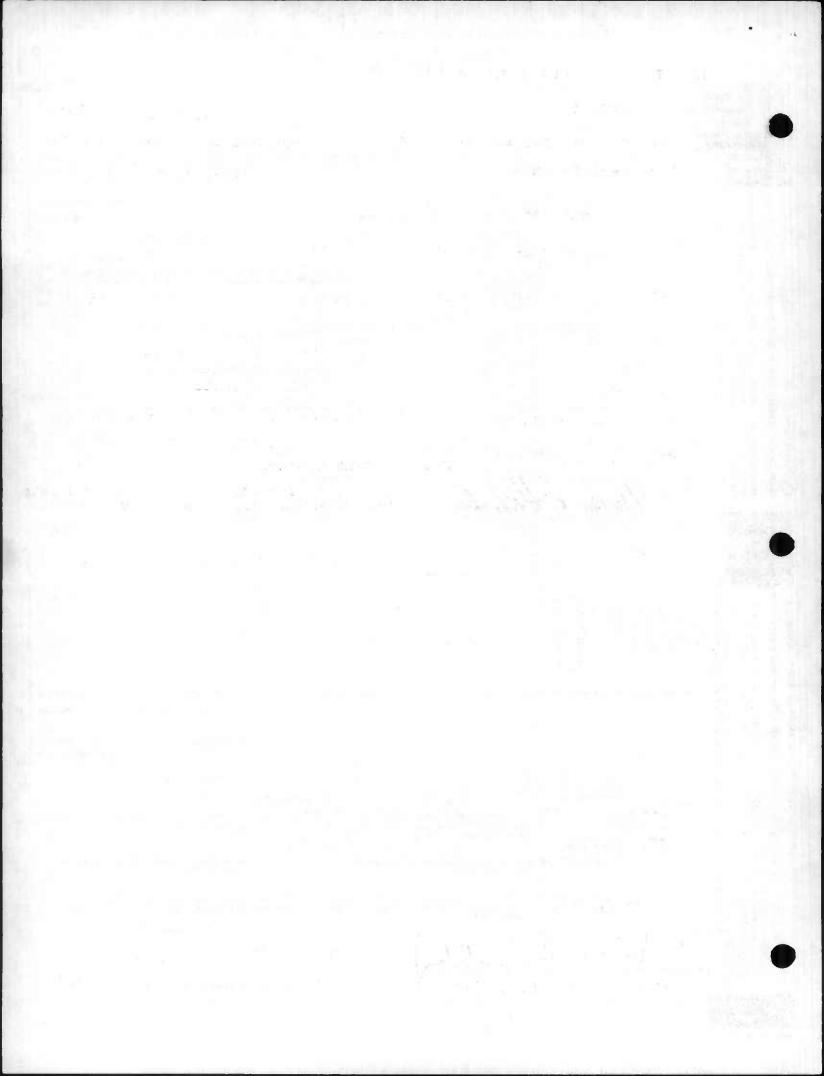
Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Deeth 3. Time of Death **Physician** Robert Lester Lee, Jr. Sept. 12,1997 5:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Undar 24 Hrs.

Months Deys Hours Min. 5. Social Sacurity Number 8. Data of Birth (Month, Dey, Yaar) 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** XI M 2 F Director 214-34-7215 63 Yrs. July 3,1934 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location items 23a or 28a-f show ner must be nothred at 10d. Insida City Limits Chester Director 1 ☐ Yas X No Md. Oueen Anne's the 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 105 Dominion Lane 21619 U.S.A. Funeral death 11 Maritel Status 12. Was Dacedent Ever In U,S. Armed Forces? Wes Dacadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuben, Maxicen, Puarto Ricen, atc.) 14. Rece - Amaricen Indian, Black, Whita, atc. permit. Pages fand 2 should be filed within 72 hours after di Department of Heart and Mental Hyglene.
Department of the 2 is marked other than "neturel", or item for injury or other traumatic event, in Medical Exercises. 1 Navar Marriad 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grade complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 18b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Seafood Waterman 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be Robert Lester Lee, Sr. Mary Elinor Schall 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 105 Dominion Lane, Chester, Md. 21619 Mary Kathryn Lee (Wife) 20b. Place of Disposition (Nama of cematary, cramatory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Dete 1 ➡ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) 997 Stevensville, Md. Stevensville Cemetery 16,1 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Fecility Fellows, Helfenbein & Newnam Funeral HOme 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiretory arrast, shock, or heart feliure. List only one cause on each line. Approximete intarval Batween Onsat and Death **Physician** Cerebrorandar accident 2 day /Medical Immediata Causa (Final disaase or condition resulting in death) Examiner Complication of endarterectory Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leeding to immadiate ceuse. Enter Underlying Ceusa (Diseese or Injury that initieted events rasulting in death) Last P.O. Box 68760. Physician/Medicai the Due to (or as e consequence of): 98 USB Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 ☐ Unknown Records, by 9 24b. Were autopsy findings available prior to pege 2 should Completed 24a. Was an autopsy performad? complation of cause of death? 1 Yas 2 No 1 Yes 2 No certificate of Vital Hospital or Attending Physician: 25. Was casa referred to medicel Be 26. Place of Deeth (Check only ona) axaminar? Hospital: 1 pmpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 250No this funeral 27. Mennar of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After Division 5 Panding Investigation 1 Matural s after deeth. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 - Homloida To the Hospital within 24 hours a To the Funeral Completely filled 15 Cartifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medicat Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a, Cartifian Medicai 29b. Signatura and title of cert 29d. Date signed (Month, Day, Year) 29c. Licansa number 32036 o complated ceuse of daeth (itam 23a) (Type, Print) 30. Nama end eddrass of person Dive Clash, MD D. O mulo 2108 2 Con 31. Data filed (Month, Dey, Year) 32. Registrar's Signature State Julia Davidson-Randell 5 Registrar

1680c V -

State of Maryland / Department of Health and Mental Hygiene 97 30682

Physicia		n: 27 per Physician, 10 1. Decedant's Nama (First, Middla, L						2. Data of De	ath Day	Year	3. Time of Death
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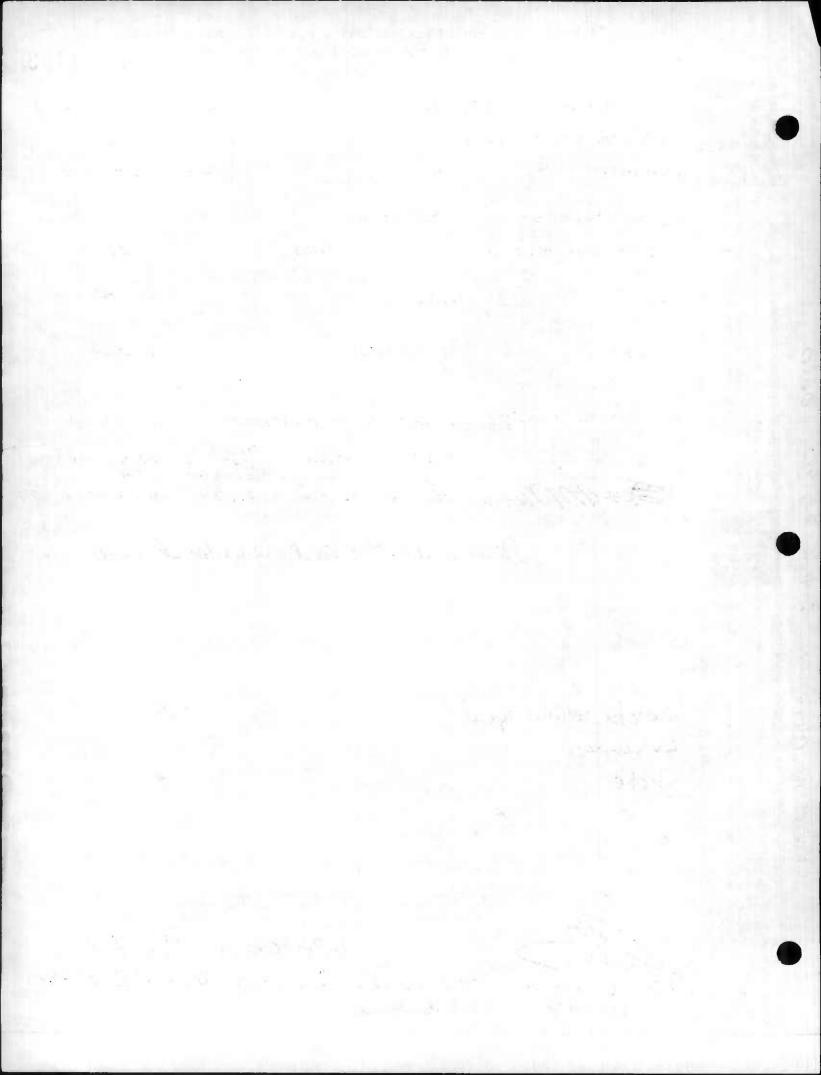
State of Maryland / Department of Health and Mental Hygiene

30683 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 4b. City, Town, or Location of Death **Physician** Charles Ray MAYES, SR. 0630 1997 /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth 9. Birthplace (Stete or Foreign Country) November 8,1920 Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 11 M 2□ F 220-05-0111 Yrs. 76 Director Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes A No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20222 Trovinger Mills Road 21740 U.S.A. Funerai 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give V Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 white naturel', or 1 Yes 2₺ No Specify: W.W.II 3 Widowed 4 □ Divorced Completed by Hygiene. other than \*nature ent, the Wedical I 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry perfit. Pages 1 and 2 should be filed within: Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "n any injury or other traumatic event, the Next College (1-4or 5+) Elementery/Secondary (0-12) machinist railroad 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel A. Mayes Etta Vott 19e. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bessie C. Niswander daughter 1047 Pope Avenue, Hagerstown, Maryland 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State Oct. 1, Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 1997 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Deeth **Physician** Interios cleratic cardio vascular discuse /Medical Immediate Cause (Final disease or condition resulting in death) Examine Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to for as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of) been signed by the eshould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? Diatetos rellitus Trett 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Luz cancer. completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Division of 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation 2 Accident within 24 hours efter deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier ş 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of territor 026806 on the Hagostan MD 21240 State Registrar

56,1982

Mayes



97-5492-043 B.K.S

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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xamin	er			GION AVEN					HAGER	STOWN		HINGTO	N
eral ctor		5. Sociel Security N 219-34-5		Gex IXIM 2□ F	ige (In yrs. le: 56	st birthdey) Yrs.	If Under 1 Months	Year Deys	If Under 24 H Hours M	in. 8. Date of B (Month, D	irth Pey, Year) ry 22,19	9. Birthpled Country 41 Wes	e (State or Foreign t Virgini
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notified at	tor	Maryland	Washing	ton		erstow						100	12 Yes 2 No
	Direc	10e. Street end Nu	imber ington Av	enue			10f. Zip C	ode 2174	40		10g. Citizen of V		?
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once.		21. Signeture of Fu	uneral Servica Licer	1500						Minnich	Funeral	Home	land <sub>21740</sub>
ian icai iner	er	23e. Pert1. Enter to shock, or hee Immediate Ceuse disease or condition resulting in deeth)	ert feilure. List only (Finel	plications that cause one ceuse on each	mysi		mio		g, such es carc	liec or respiratory	arrest,	In	pproximate tervel Between nset end Deeth
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iuneral ullector, page z snoulo be delached for use as the	To Be Completed by Physician/M	Pert II. Other elgnif	ficant conditions of the first tending to medical No.	ontributing to death  Hospital: 1 □ Inpat  28e. Dete of Inj (Month, De	but not resulti	ing in the unc	derlying cau	Othe	26. Plece of D	24a. We per 100 and 10	s an autopsy formed?  Yes 2 No one)  oldenca 6 Oth	3 Probat  24b. Were availe comp of der  187  eer (Specify) red	eutopsy findings bible prior to letion of cause th?  Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Solution of Sol
מוסמת מוסקים: "אמלים אי מוסקים בין מסק מיות מיות מיות מיות מיות מיות מיות מיות	To Be Completed by Physician/M	Pert II. Other eignif  25. Wes case referexeminer?  XXYes 2   27. Manner of Deat	ficant conditions of the condi	Hospital: 1   Inpat	but not resulti	R/Outpetient  8b. Time of Injury  \$3.2 e, farm, street	3 DOA	Othe	26. Piece of I	24a. We period of the control of the	Sees 2 No s an autopsy tormed?  Yes 2 No one) sidenca 6 Oth how injury occur  (Street end Numb wm, Stere)	24b. Were availe comp of det	eutopsy findings ble prior to letion of cause th?  es 2 \sum No
al director, page 2 should be detached for use as the	To Be Completed by Physician/M	25. Wes case referencement of the limited events of the limited ev	Ilcant conditions of the conditions of the condition of t	Hospital: 1 Inpat	ient 2 Er  ury By Year) 1 97  ijury - At hom to. (Specify) for my known of exemination	R/Outpetient  8b. Time of Injury  \$3 2 e, farm, street	3 DOA  28c  AM  at, factory, or	Other	26. Piece of I	24a. We peril	Ses 2 No s an autopsy tormed?  Yes 2 No one) sidenca 6 Oth how injury occurr  (Street and Numb own, Stete)  A Cause(S) and ma	24b. Were availe comp of det 1997  er (Specify) red  over or Rurel R	eutopsy findings ible prior to letion of cause ath?  es 2 \subseteq No

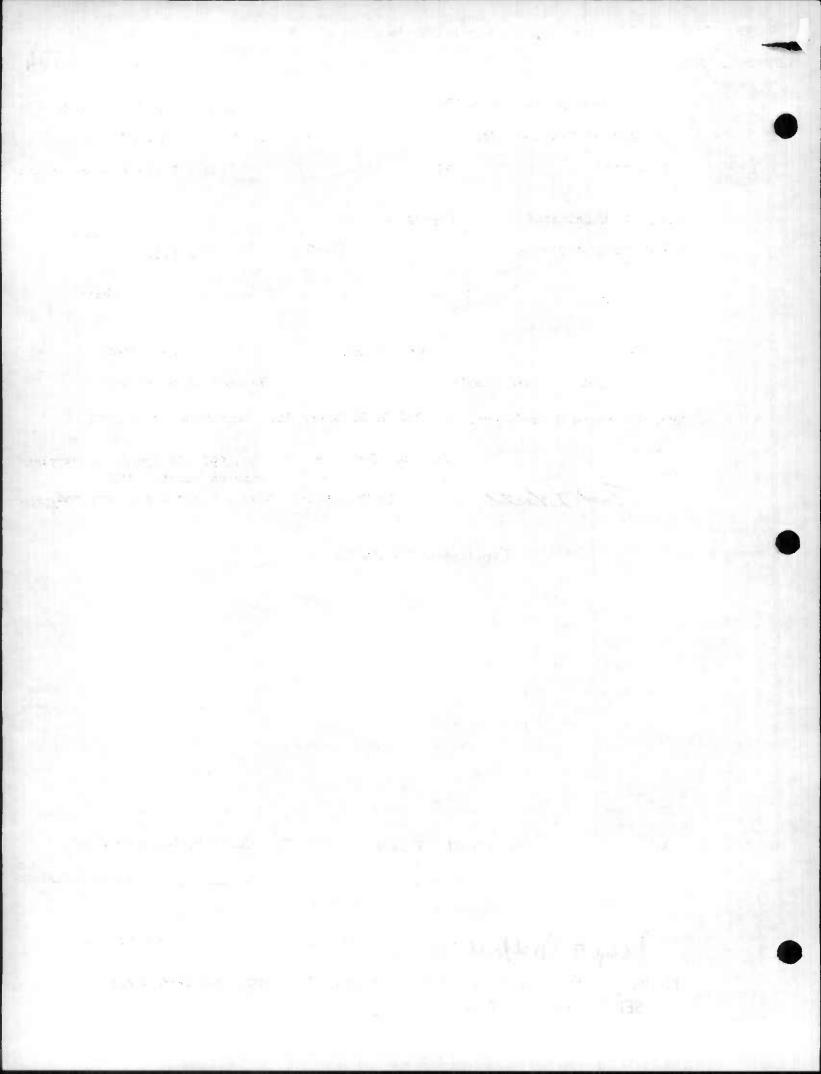
State Registrar

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

YARYS WAY 111 Penn Street, Baltimore, Maryland 21201

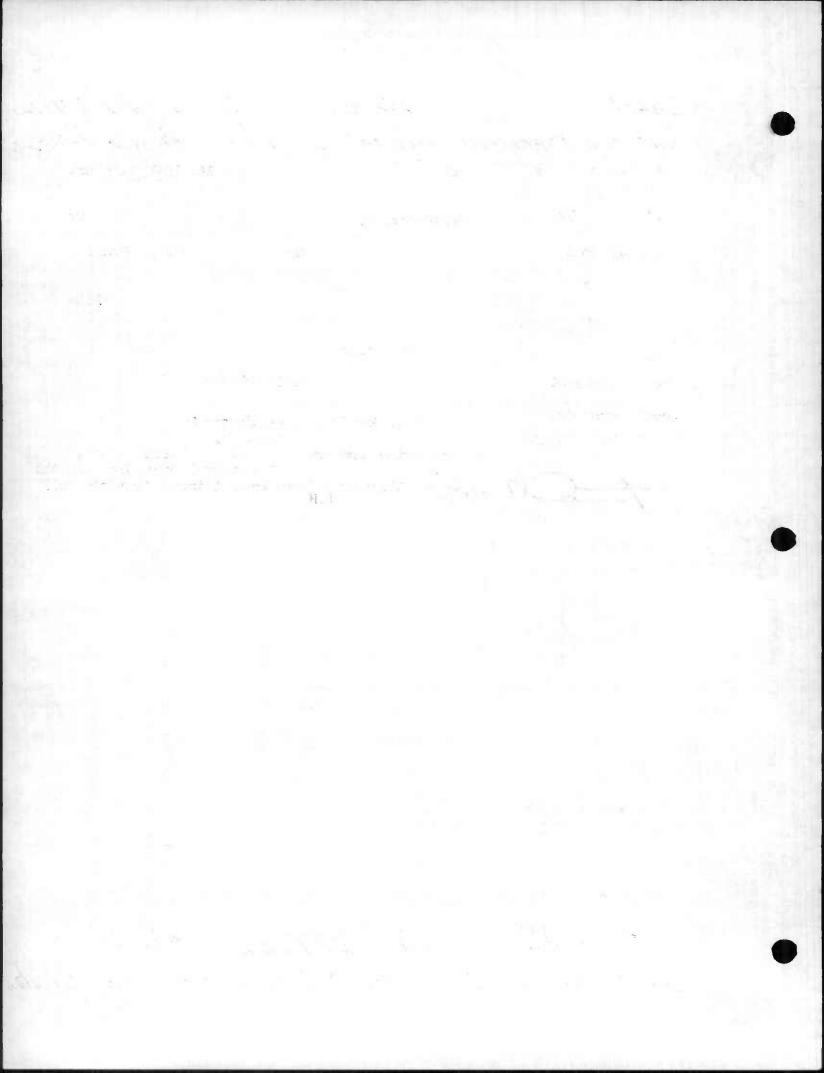
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SEPT. 27, 1997



State of Maryland / Department of Health and Mental Hygiene

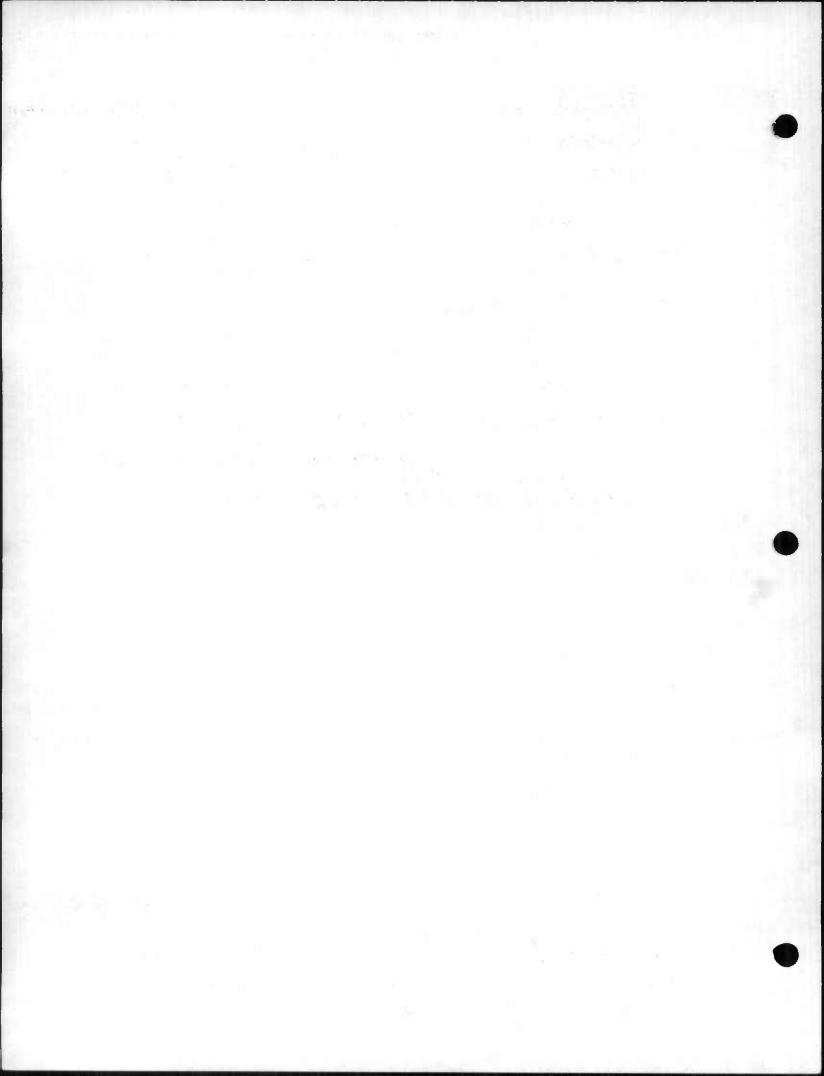
hysici	an	Decedent'a Nama (First, Middle, Last,			Certifica	. /		2. Date of D	Reg. No. eath Day	3. Time of Death
/Medic Examin	al	AROL A Figure (If not institution, give	street and number)	145	MACI			Location of Dea	th 4c County	797 J.41 m
ineral rector		5. Social Security Number 6. Security Number 070-34-8453	7. Aga (In )	rs. lest birth	Month	er 1 Year s Days	If Under 24 Hr. Hours Mir		irth (ay, Year)	9. Birthplace (State or Greigh County) New York
show	2	10a. State 10b. County N/A N/A		City, Town						10d. Inside City Limits
3a or 26a-f	Funeral Director	10e. Street and Number P.O. Box 59249	Wa	shing	ton DC	Zip Code Unkr	own		10g. Citizen of V	What Country?
onant: If item 27 is marked other than "naturel, or items 23s or 28s-f show injury or other traumatic event, the Medical Examinet rout be notified at	by		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Yaar or Dates:	n U,S.		pedent of His pecify Cubar		Specify Yas or N nto Rican, etc.)		e - Americen Indian, ck, Whita, etc.
the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elamantary/Secondary (0-12)	cation e completed) Coilege (1-4or 5+) N/A		Decedent's United Rive kind of the DO NOT COMEMAL		tion uring most of we	orking	16b. Kind of B	usiness/Industry
rked otheric event,	To Be C	17. Fathar's Nama (First, Middla, Last) Frank Schmardel						<sub>ame (First, Middle</sub> Schafer	e, Meiden Suman	na)
27 ls mar r traumat	-	19a. Informant's Name/Relationship (Ty Lester Mackovick	pe, Print)		Mailing Addre			Aural Route Numb	ber, City or Town,	Stete, Zip Code)
Injury or othe		20a. Method of Disposition  XXX urial 2 Cremation 3 A 4 Donation 5 Other (Specify)	emovai from State	b. Place of Cometary,	isposition (A crametory o	lame of r other place meter	) Sept	2. <b>2.9</b> ,	20c. Location - Staten	City or Town, State Island, NY
amy Inj		21. Signature of Funeral Service Licens	Xa. 40/9	4	22. Name Alexar	and Addrass	of FacilityLet Ferry R	e Funera oad, Cli	il Home, nton, Ma	Inc 6633 Old aryland 20735
ician dical niner	ner	23a. Part. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Fulm	O (or as a co	nsequence c	rmay	La -	ac or respiratory	arrest,	Approximata Interval Between Onset and Death
use es the burial-transit	8	Sequantially list conditions, if any, laading to immediate ceuse. Entar Underlying Causa (Disease or Injury that initiated events resulting in daath) Last	Jew to	(or as a co	nsequence o	steu	DS15	nduis	( End	
ched for	Physician/M	Part II. Other significant conditions con	tributing to death but not	rasulting In t	ha undariyin	g cause giva	n in Part I.			ntribute to the cause of death
should be deteched for use ea	þ							24a. Wa	Yes 22 No	3 Probably 4 Unknow  24b. Were autopsy findings
page 2 sho	Completed								ormed? Yes 20⊠ No	available prior to completion of cause of death?
director		25. Was cesa raferrad to medicel examiner?  1 \subseteq Yes 2 \subseteq No	ospital: 1 Inpatient 2	.□ ER/Outp	atient 3	DOA Othe		eath (Check only	one)	er (Specity)
the funera		27. Mannar of Death  1 🖾 Natural 5 □ Pending 2 □ Accidant investigation 3 □ Suicide 6 □ Could not be	28a. Date of Injury (Month, Dey Year)		M M		at ? es 2 □ No	1100	how Injury occur	
letely filled in by		4 ☐ HomicIde determined	28a. Place of Injury - A building, etc. (Specials)	ecify)			date and piece	City or To	own, State)	per or Rural Route Number,
completely filled in	Medical		er: On the basis of exam and manner stated.	Ination and/	or invastigation	on, In my opi	nion, death occ	urred at the time	, date and place, 29d. Date signe	and dua to the causa(s)  d (Month, Day, Year)
	-	30. Name and address of person who co	JAN J	ML	. Reint)	D3	736	6	03/2	5/97 #262 C/WI
		Camp Shah	Chab M.	(1)	7RA	101	1 Ro	auch	AND.	4200 11.



State of Maryland / Department of Health and Mental Hygiene

97 3068

						Certific	ate of	Death	)	Re	g. No.			
	A	. 1	1. Decedenl'a Neme (First, Middle,	ast)						2. Dete of Deeth	1	Vaar	3. Time	of Death
	Physic /Medi		Elwood C	. Marsh						Month 9	20	1997	12:	00 PM
	Exami		4a. Fecility Nema (If not institution, g	rive street end number)				4b. City, To	own, or Lo	cation of Deeth	4c. County			
			3904 Little				da A V	West			Ca	rrol1		
	Funeral Director		5. Sociel Security Number 166–12–5899  Usuel Residence of Decedent	Sax 7. Age	(In yrs. last bir 76	Yrs. Mont	hs Deys		Min.	8. Dete of Birth (Month, Day, Dec. 1,	1920	9. Birthp Coun	place (Stete htry) MD	or Foreign
	Maryland a-f show	tor	10a. State 10b. County  MD Car	rol1	10c. City, Town	n or Location minste	r					11	0d. Inside (	City Limits
	th with the 23a or 28	ai Director	10e. Street end Number 3904 Littlestow	n Pike			Zip Code	.158		10	g. Citizen of U.S		itry?	
020	be filed within 72 hours after deeth with the Maryland stal Hyglene. Id other than "naturel", or flems 23a or 28e-f show event, the Medical Evantrer must be modeled at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Merried  3 ☒ Widowed 4 □ Divorcad	12. Was Decedent E Armed Forcas?  1 1 1 2 Yas 2 1 No If Yes, Give (Year or Detas: 4	0		specify Cut			ecify Yes or No- Rican, atc.)		ce - Americ ck, White, y: Whi	etc.	
Maryland 21215-0020	hin 72 ho e. in "natur Medical	Completed	15. Decedent's (Specify only highast (Elementary/Secondary (0-12)	Education	16e.	Decedent's U (Give kind of life. DO NO	work done	during mos	st of worki	ina	66. Kind of B	usiness/Inc	dustry	
21	al Hyglene. I other than vent, the Me	on	8	Conlege (1 Hor C4	7	Welde	r				Manuf	actur	er	
bu	of H	Be	17. Fathar'a Nama (First, Middle, La	st)				18. Mothe	er's Name	(First, Middle, M	laiden Sumen	ne)		
<u>a</u>	inould be filed vidential Hygie marked other imatic event, II	To	Clarence Mar	sh						Catheri	ne E. I	Hann		
Man	듀포트를		19e. informent's Name/Reletionship Ray D. Marsh			. Mailing Addi 4736 B				al Routa Number, neytown,	-	, State, Zip 1787	Code)	
Baltimore,	permit. Page-1 and Depertment of Health Important; if Nem 27 Is any Injury or other tra		20e. Mathod of Disposition  1 X Buriai 2 Cremetion 3 4 Donation 5 Other (Special Control of Control			Disposition ( y, cramatory ary's	or othar pla	,	9		Westmi			
Balti	Dependit. Importal any Inju		21. Signeture of Funarai Service L/o	/	,00	22. Name	and Addr	ass of Facili	ity					
	-		23a Part 1 Enter the disease or co	molications that caused	the death the	Little	e's F	ha such as	34 Ma	aple Ave	. Litt	lesto	wn, PA	
	Obveleion	-	23a. Part1. Enter the diseasa, or co shock, or heert feilure. List on	ly one ceuse on each line	9.	annar tria	nooa or ay	ang, saon es	cardiec (	or reaphrotory erro	ot,		Intervei Be Onset and	etween
) '	Physician /Medical		immediete Cause (Finai	colo	10	Cou	21	0 -					2 4	
	Examiner		disease or condition resulting in deeth)	a.								<u> </u>	7 4	5
31		ě			Due to (or as e	consequence	of):					i i		
	nsit	듄		b		,	40	<u> </u>						
60,	be axecu ician and burial-tre	al Examiner	Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Couse (Disease or injury	c	Dua to (or es e	consequence	of):							
x 68760,	aath certificata be axecuted attending physician and for use es the burial-trensit	Medical	thet initieted avents rasulting in death) Lest	D	ue to (or as a d	consequenca	of):					1		
	death c e attence ed for us	Physician/												
	the da ny the a	ysic	Pert it. Other significant conditions	contributing to death but	not resulting Ir	the underlying	ng cause g	iven in Pert	1.	23b. Dld tol	DACCO USO CO	intribute to	the cause	of death?
σ.	that date	by Ph								1 🗆 Ye	2 12 No	3 Prot	pably 4	Unknown
	e law requiras hes been sign ge 2 should be	Completed								24e. Wes en periorm		6A1	ara autopsy aiteble prior mpletion of deeth?	rto
	0 - 7	no.								1 ☐ Ya	s 2 No	10	Yas 2	No
		Be (	25. Wes case referred to medical examinar?					26. Place	e of Deeth	n (Check only ope	o)			
>	5 50	To	1 ☐ Yas 2 ☐ No	Hospitei: 1 ☐ inpatien	t 2 ER/Ou	tpatient 3	DOA OI	ther: 4 🗆 Nu	ursing Ho	me 5 Reside	nca 8 🗆 Oth	ner (Specify	y)	
			27. Menner of Daeth	28e. Dete of Injury (Month, Day	(Vear) 28b. 1	Tima of	28c. inju	ury et		28d. Describe ho	w injury occur	rred		
5	l or Attending I after death. Director: After I in by the funer	Certification:	1 Netural 5 Pending invastigal 3 Suicide 4 Homicide	ba Disconfigure	ry - At home, fe	М	1[	Yes 2		28f. Location (Str City or Town		ber or Rura	I Route Nu	m <i>ber</i> ,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C		Physician: To the best of aminer: On the basis of a end menner steto	examination and									(s)
	To the To the comple	Me	29b. Signeture end title of cartifiar	a Mi	.1			sa number			d. Dete signe			007
			30. Neme and eddress of person wh	o completed cause of de	eth (Item 23e) (	(Type, Print)	VIII 3	1079	- 6	13 (	promo	er z	- < 1 /	77/
	CA	***	11 11 /		Se Signature	treet	Hon	oup	- P	S. 12	371			
	Sta	ne	CED 0 5 10	107 1.1. 14	1. 0	0 .1								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth Month CHARLOTTE FLORENCE NESLER 4b. City, Town, or Location of Death 4a. Facility Nema (If not institution, giva street and numbar) 4c. County of Deeth Washington County Hospital Hagerstown Washington ff Undar 1 Yaar | If Under 24 Hrs. | 8, Date of Binh Months | Deys | Hours | Min. | Jan. 2, 5. Social Security Number 9. Birthplaca (Stata or Foraign Country) Bayonne, NJ 7. Aga (In yrs. last birthday) 1 M XX 158-10-2334 Yrs. Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No MD Washington Hagerstown 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? Ravenwood Lutheran Village 21740 USA 12. Was Dacedenl Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yas, Giva Yaar or Detes: Was Dacadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - American Indian, Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: Specify. 3 Nidowad 4 Divorced White 15. Decadent's Education 16a. Dacedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) 12 Collaga (1-4or 5+) Homemaker Private Residence 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Charles Frank Lydia May Frank 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Patricia L. Holbert, Daughter 1230 Redwood Drive, State Line, Pennsylvania 17263 20a. Method of Disposition 20b. Place of Disposition (Name of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Slete Rest Haven Cemetery Sept. 30 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funaral Service Licansae 22. Nama and Addrass of Facility
Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 tions thet causad tha daeth. Do not antar tha mode of dying, such as cardiac or respiratory arrest, causa on agch lina. Approximete Interval Batween Onset and Deeth Immediale Causa (Final disaasa or condition rasulting in death) Sequantially list conditions, if any, leading to immadiata cause. Enfar Undarlying Ceusa (Disaase or Injury that initieted avants resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findinge availabta prior to 24a. Was an autopsy performed? completion of causa of daath? 2 1 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat axaminar? 26. Place of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 1 Detient 2 ER/OutpatianI 3 DOA Dete of Injury (Month, Day Year) 27. Menner of Beet 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes

**Examiner** Murence Division of Vital Records, death. within 24 hours after deat To the Funerel Director:

is certificate has been signed by the ettending physician director, page 2 should be detached for use as the burie Physician/Medical þ Be Completed 70 Certification: 6 edicai

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

6 items 23a

6

"natural",

Hygiene.

other

other traumatic and I

the Medical Examiner must be notified at

Director

Funeral

Completed by

Be

the Maryland

filed within 72 hours after

2 Mental

Pages 1 and 2 should

permit. Pages 1 and 2.
Department of Health a important: if item 27 is any injury or other trains.

**Physician** /Medical

Maryland

Baltimore,

After this

1 | Yae 2 |

1 [ Matural 2 Accident 3 Suicide 4 Homicide

(Check only

6 ☐ Couid not ba determined

2 9 1997

28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify)

Road

Location (Straat and Number or Rural Routa Number, City or Town, Stata)

Hagerstown Maryland

1 Certifying Phyeician: To the best of my knowledge, deeth occurred at tha time, dete end placa, and dua to the cause(s) end mannar es steted.
2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. 29c. Licansa number 29d. Date signed (Month, Day, Year)

30. Name and eddrass of person who complated cause of deeth (Itam 23a) (Type, Print)

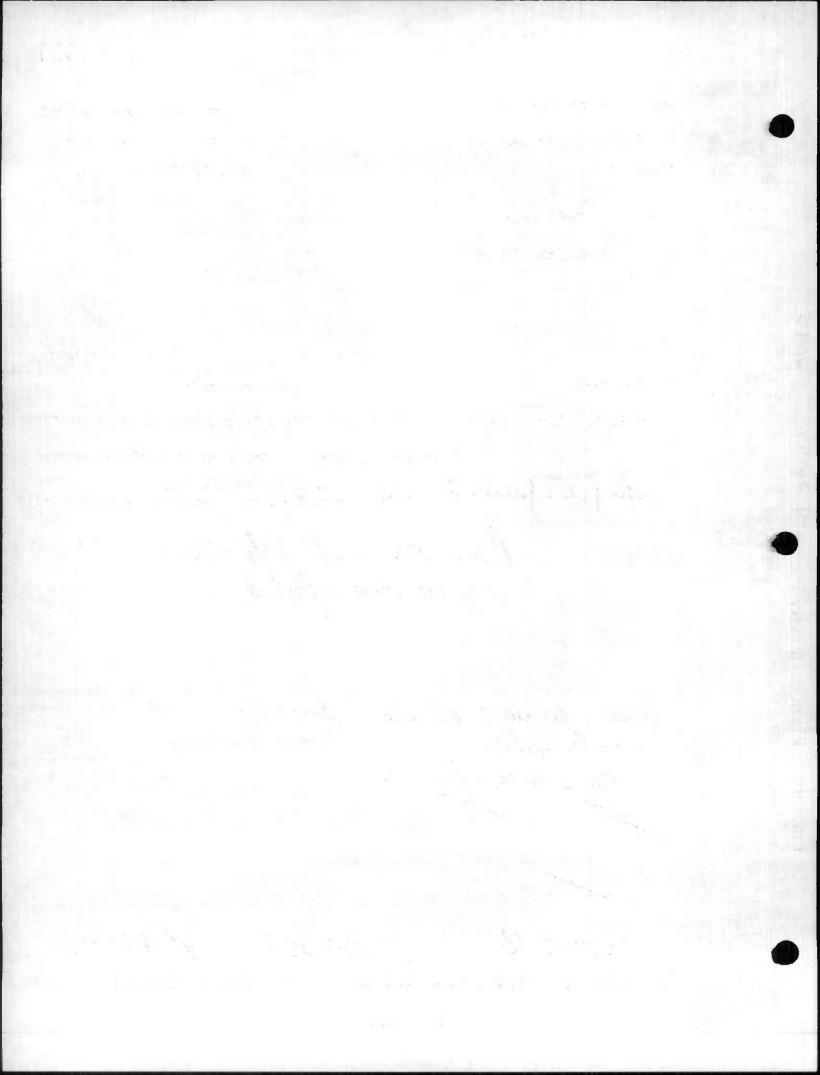
31. Data fited (Month, Day, Year)

29b. Signatura and title, of cartifiar

1185 32. Registrar's Signetura

Relia Davidson

State Registrar

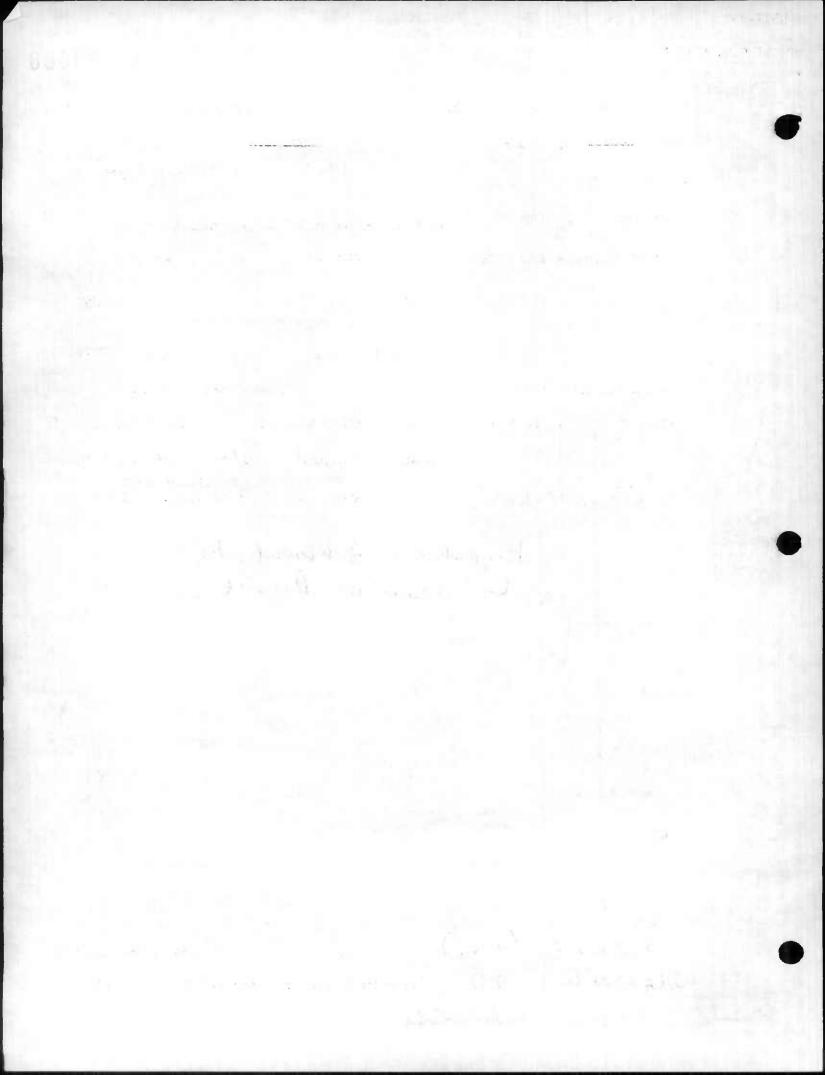


State of Maryland / Department of Health and Mental Hygiene

ems:4a,b	-	r MEO G-753 11/3/97 dl	1			ificate of			g. No.	)	30688
Physician /Medical		1. Decedent's Name (First, Middle, La: CATHERINE	JULIA I			1		2. Date of Death Month SEPTEMBE	Dey ER 18,	Year 1997	3. Tima of Death 0845 AM
Examiner		Na. Facility Name (If not institution, given Parsons  40530 PARMUS MILI  5. Social Security Number  6. S	ROAD	r) Age (In yrs. last	birthday)	If Under 1 Year	4b. Cify, Town, or Lo Leonardtowr LOVEVILLE If Under 24 Hrs.	1		ARY'	S COUNTY
Funeral Director			□м 25€ F	55	Yrs.	Monfhs Days	Hours Min.	8. Dafe of Birth (Month, Day, OCT 19,	Year) 1941	MARY	place (State or Foreign http) LAND
28a-f show notified at	-1	10a. State 10b. County  MARYLAND ST. MAR	Y"S	10c. City, To		rsons	Mill Rd				1 ☐ Yes 2X No
23a or	3	10e. Straat and Number 40530 Parsons				10f. Zip Code 2065			g. Citizen of t		
by by	2	11. Marifal Stafus  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Year or Dates	? <b>K</b> No		as Decedent of I es, specify Cub  Yes 2 No	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ck, White,	ean indian, etc.
ygiene. hr, tra Medical Exat. nt, tra Medical Exat. Completed by	The state of the s	15. Dacedent's Ed (Specify only highest gra Elementary/Secondery (0-12)	da completed) College (1-4or		(Give ki life. D	NOT use retire	during most of worki	ing 1	6b. Kind of B		dustry OMPANY
d out	3	17. Fathar's Name (First, Middle, Last)  MELVIN CHARLES G	ESELL		PSI	CHOLOGIS	18. Mother's Name	e (First, Middle, M	laiden Suman	ne)	JAPANI
of Heelth ar		19a. Informant's Name/Relationship (i BERYL C. GESELL, 20e. Method of Disposition 1 □ Burial 2 反 Cremetion 3 □ 4 □ Donation 5 □ Other (Specification)	MOTHER  Removal from State	20b. Place	205 of Disposi		1	511, WES	TMINST Oc. Location	ER, I	MD 21157 own, State
Department of Important: If any Injury or 200ce.		21. Signeture of Funeral Service Licen		ine.	22.	Name and Addre	on of English	INE FUNE		ME	
ding physician and lise as the buriel-transit using the work of th		Immediate Ceuse (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury hat Initiated events resulting in deeth) Last	a. Hy Ca c.	Due to (or as Due to (or as	a conseque	ence of):	Disea	se se			Onsel and Death
igned by the attending be detached for use a by Physician/M		Part II. Other significant conditions or	entributing to death	but not resulting	In the und	erlying cause gh	ven in Part I.			ntributa to	o the causa of death?
2 should								24e. Wes an	autopsy sed?	av	ere autopsy findings ailebte prior to mpletion of causa deeth?
certificate harector, page		25. Was case referred to medical					26. Place of Death	1 (Check only one	s 2 No	1/2	Yes 2□ No
this certific al director, To Be		examiner? 1⊠ Yes 2□ No	Hospital: 1 ☐ inpat		Outpetient	3LI DOA		me 52 Resider	-		(y)
After		27. Menner of Deeth  1 Naturel 5 Pending 2 Accident Investigation 3 Suicida 6 Could not be	28a. Date of Inj (Month, D		o. Tima of Injury		rk?  Yes 2□No	28d. Describe ho			
s after deeth. If Director: A sid in by the factor in by		4 Homicide determined	28e. Placa of Ir	njury - At home, itc. <i>(Specify)</i>	farm, stree	t, facfory, office		28f. Location (Str City or Town,		ber or Hure	il Houte Number,
within 24 hours after deets To the Funeral Director: completely filled in by the Medical Certificat				of examinetion			me, dete and place, oppinion, deeth occurr				
To the compl		29b. Signature and title of certifier	les	1.0		29c. Licens			d. Date signe		
	:	30. Name and address of person who d	completed cause of	death (Item 23a	a) (Type, Pi		C.M.E.	5	SEPTEME	BER 1	9, 1997
		OLA KON WC	to, M	trar's Signature	111 P	enn Stre	et, Balti	more, Ma	aryland	212	01

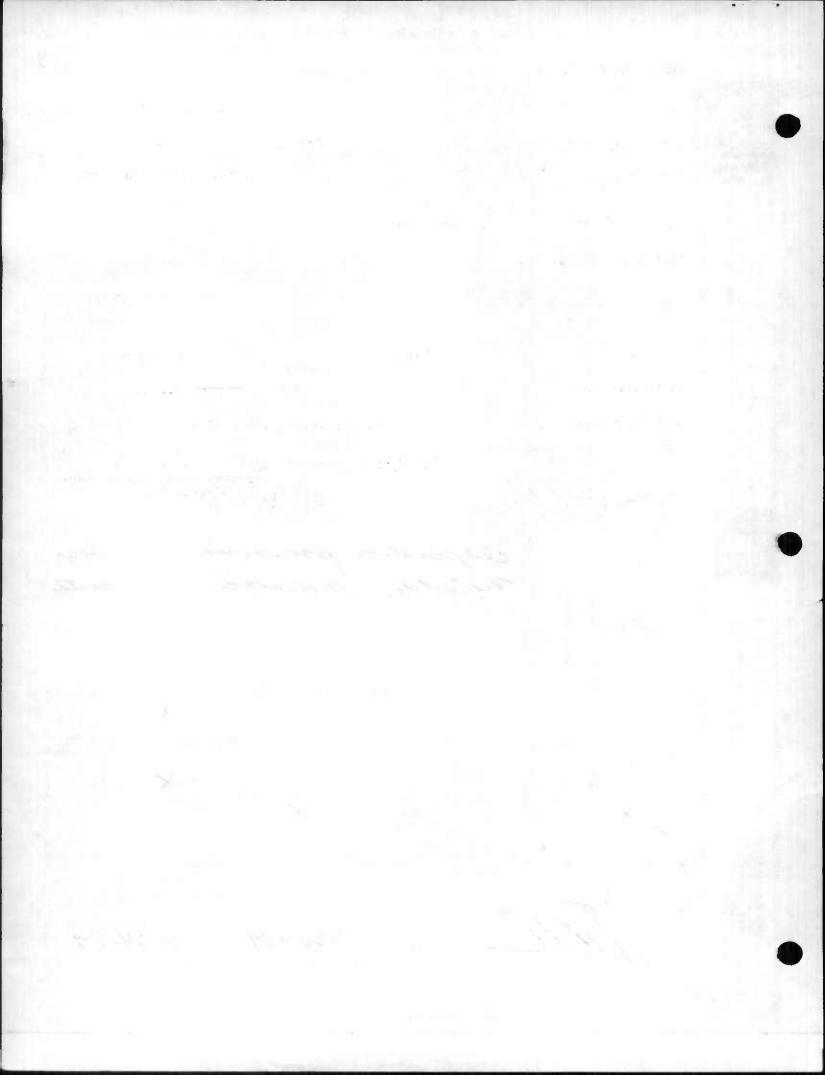
Registrar

SEP 2 4 1997 Jali Devoler Rosel



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

Dharata		ITEM#18 PER F.H. FLM#( 1. Decedent's Name (First, Middle, Las		0.A.	Certificate of	Death	2. Dete of D		3. Time of Dea
Physic /Medi		John L. Pickett					Month Sept.	24, 19	97 6:30 A.
Exami		4e. Fecility Neme (If not institution, give	street and number)			4b. City, Town, or			
		North Hampton Man	or			Frederic		Freder	ick
Funeral Director		5. Sociel Security Number 6. Security Number 214-14-6175 Usuel Residence of Decedent		(In yrs. lest bii 94	rthdey) If Under 1 Yeer Yrs. Months Deys		(Month, D	irth Pay, Year) 9, 1903 M	9. Birthplece (State or For Country) [aryland
netural", or items 23s or 28s-f show		10a. Stete 10b. County	1	IOc. City, Tow	n or Location				10d. Inside City Lin
1	cto	Maryland Howard		Woodb:	ine				1 ☐ Yes 2大
or 2	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of Wi	net Country?
23		1421 St. Michaels	Rd.		21797			United St	ates
Hem .	Funeral	11. Maritai Status	12. Wes Decedent Ev Armed Forces?		13. Wes Decedent of If Yes, specify Cut	Hispenic Origin? (S	Specify Yes or N to Ricen, etc.)	o- 14. Race Bieck	- American Indien, White, etc.
Fram.	by F	1 Never Married 2 Merried	1 ☐ Yes 2 🛂 No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
natural',	P	3 Widowed 4 □ Divorced	Yeer or Detes:	1.77		SIE			
iene. r than "natur in Medical	Completed	15. Decedent's Edu (Specify only highest great	ucetion de co <i>mpleted)</i>	16e	<ul> <li>Decedent's Usuei Occu (Give kind of work done life. DO NOT use retire</li> </ul>	pation during most of wo	rking	16b. Kind of Bus	Iness/Industry
then.	dmo	Elementery/Secondery (0-12)	Coilege (1-4or 5+)	_		90)			
Hygiene. ther than		5th 17. Fether's Neme (First, Middle, Last)		l F a	armer	19 Mother's No.	me (First Middle	Agricul  B. Meiden Sumame	
la de	Be	Matthew Pickett							
th and Mante 7 Is marked treumatic e	To		and Briefl	1401	A4-W A 44 - (O)			on MOLLINIX	
le le		19e. Informent's Name/Reletionship (T)			. Meiling Address (Stree				
m 2		Calvin Pickett ( 20e. Method of Disposition	Son)	20h Place 0	421 St. Mich	naels Rd.			
Depertment of He eny injury or ot ones.		₩ Buriai 2 Cremation 3 🗆	Removel from State	cemete	f Disposition (Neme of ry, cremetory or other pla	ece)	Dete	20c. Location - C	ity or Town, Stete
tant tank		4 Donetion 5 Other (Specify)	)	Poplar	Springs Ce	emetery 9	/27/97	Woodbine	, MD
Deper Impor eny in		21. Signeture of Funerei Service Licens	200		22. Name end Addre	ess of Fecility B	urrier-	Queen Fun	eral Home
0 - 0		100011 he	lener			1212 W. Winfield	MD 21	erty Rd.	
Medical xaminer	Jer	Immediate Cause (Finel disease or condition resulting in deeth)	· Ols	ne to (or es e	consequence of):	yeus velva	ma		doys.
g physician and es the bunal-transit	al Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury			consequence of):				7,7700
	n/Medical	resulting in deeth) Last	Du d	e to (or as a	consequence of):				
e attendir	icia	Pod ii Other elgolficent conditions co	edelle stiere to along the feet		- 45	on in Donat	001 DI		
y th	y Physician/M	Pert II. Other eignificant conditions co	minouting to death but i	not resulting i	n the underlying ceuse gr	ven in Pert I.		1.	ribute to the cause of de
s been 2 shoul	Completed by							s en eutopsy formed?	24b. Were eutopsy findin aveilable prior to completion of ceuse of deeth?
pa	So						1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No
certificete rector, pag	Be	25. Was case referred to medical exeminer?				26. Plece of De	eth (Check only	one)	
this di	tion: To	27. Menner of Deeth 1 Naturel 5 Pending	1 Inpatient 28e. Dete of Injury (Month, Dey Y	28b.	Time of 28c. Injury Wo			how injury occurred	
within 24 hours efter death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Piece of injury building, etc. (	- At home, fe 'Specify)	erm, street, factory, office	11111		(Street and Number own, State)	or Rural Route Number,
n 24 hours e	edicai	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	elcien: To the best of mer: On the basis of exercise end menner state.	caminetion en	e, deeth occurred et the ti d/or investigetion, in my o	me, dete end piece opinion, deeth occu	e, end due to the urred et the time	e ceuse(s) end man , dete and piece, en	ner es steted. d due to the cause(s)
To the comple	M	29b. Signeture and fills of certific	_		29c. Licen:	se number 2649	9	29d. Date signed 9 - 2	(Month, Dey, Yeer)
	. 1	30. Name and address of person who co							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ANTHONY JOSEPH PELUSO 21, 1997 8:08 PM SEPTEMBER

**Physician** /Medical **Examiner** 

4a. Fecility Neme (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death

Towson

4c. County of Death Baltimore

**Funeral** Director

> 28a-f show must be notified at

Herrie 23a

b

traumatic event, the Medical Examiner

h and Mental It is marked of

Item 27

**Physician** /Medical

Examiner

end

ettending physician

signed by the

has

certificete

funeral director,

in by the

24 hours

To the To the To the

the

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

Medicai

8

Pages 4-End 2 should be

Funeral

by

Completed

Be

Usual Residence of Decedent

5. Social Security Number

214-18-2583

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 1/20/1923

Birthplace (State or Foreign Country)

10e State

10b. County

10c. City, Town or Location

Yrs.

MARYLAND

MARYLAND

CARROLL

WESTMINSTER

10d. Inside City Limits 1 ☐ Yes 2 🛛 No

Director 10e. Street and Number

2616 NEUDECKER RD.

21157 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.)

10f. Zip Code

10g. Citizen of What Country?

USA.

14. Race - American Indian, Black, White, etc. Specify:

1 Never Merried 2 Married 3 Widowed 4 Divorced

1 Yes 2 No Specify:

Days

WHITE 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12)

College (1-4or 5+)

10XM 2□ F

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MECHANIC

AUTOMOBILE REPAIR

17. Fether's Neme (First, Middle, Last)

8

JOSEPH

**PELUSO** 

7. Age (In yrs. last birthdey)

74

18. Mother's Name (First, Middle, Maiden Sumeme) ELIZABETH

GRAZIOSI

19a. Informant's Name/Relationship (Type, Print)

19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

SUZANNE E. PELUSO -DAUGHTER 2 MULLIGAR CT.#102, TIMONIUM, MD. 21093

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State

20a. Method of Disposition

XIXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify)

MEADOW BRANCH CEM.

9/25/97 WESTMINSTER, MD.

22. Name end Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

MULTIPLE ORGAN FAILURE SYNDROME

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of) Due to (or as a consequence of):

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.

Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

DIABETIC CARDIOMYOPATHY

24e. Was an autopsy performed?

24b. Were autopsy findings eveilable prior to completion of cause of death?

1 ☐ Yes 2 No

TOWSON, MARYLAND

26. Piace of Death (Check only one)

1 ☐ Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation

6 Could not be

M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Dey Year)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Deeth

1 Naturat

2 Accident

3 Suicide

4 - Homicide

TO Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

nohoo

D30263

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO,

31. Date fited (Month, Day, Year) SEP 2 5 1997

7620 YORK ROAD M. D. 02. Registrar's Signature

**DHMH 16 Rev 6/95** 

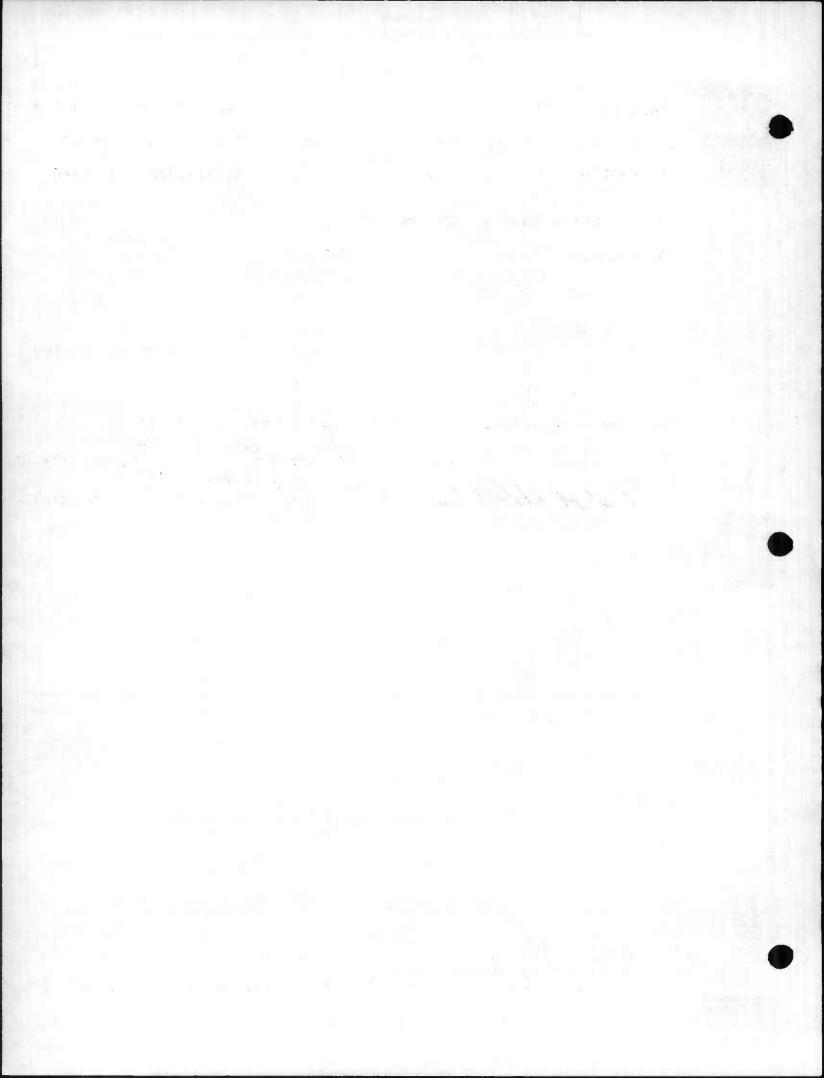
The law requires that the death certificate be executed P.O. Division of Vital Records, I or Attending Physician: efter death. Director: After this certifice

Box 68760.

State Registrar

State of Maryland / Department of Health and Mental Hygiene Q 7 20601

					,	Cen	tificate of			Reg. No.	1	16900
	Dharaia		1. Decedent's Name (First, Midd	le, Last)					2. Date of De Month	ath	Voor	3. Time of Death
	Physic /Medi		Glenn Walter	Pippin					Sept.	8 Day 19	97"	9:05 a.m
	Exami		4a. Fecility Name (If not institution					4b. City, Town, or				
			Corsica Hill				www.	Centrev				nne's
k	Funeral Director		5. Social Security Number 214-30-8056	6. Sex 7. As	ge (In yrs. last bi	rthday) Yrs.	Months Days		8. Date of Bir Month, De Aug. 7	, 1932	9. Birthpl Count Mary	lace (Stete or Foreign try) Yland
	pue *		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, Tow	m or Loc	ation				16	Od. Inside City Limits
	Manyl 4 sho	ō	MD Oues	en Anne's	Centr							1⊠ Yes 2 No
	1 28a	rec	10e. Street and Numbar		001101		10f. Zlp Code			10g. Citizen of	What Coun	try?
	h with	a D	205 Armstron	g Street			21617	7		U.S.		
21215-0020	72 hours after death with the Maryland natural; or items 23s or 28s-1 show area: Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	If Ves Give			/as Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No to Rican, etc.)	14. Rad Bla Specif	ce - America ck, White, c	
0-0	n 72 hours	pet		nt's Education	16a	Decede	ent's Usual Occi	pation		16b. Kind of B	usiness/ind	lustry
215	5 -4	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed)  College (1-4or)				upation e during most of wor ed)	rking			
	filed with Hygiene. ther ther	Con	12		Di	rec	tor/Ch	airman		Crimi	nal J	Justice
Maryland	o a a o	To Be	17. Father's Name (First, Middle, Thomas S. Pi					18. Mother's Nar Sarah	ne (First, Middle Cours		ne)	
	d2 sho th and 7 is me traum		19a. Informant's Name/Relations Anne Nehring/					of and Number or Ru 97, Secre	tary,	MD 21	664	
Baltimore,	S 0 4 5		20a. Method of Disposition  1				ition (Neme of etory or other pl	cemetery	ept. 1	1 , 1997	- City or To	wn, State eville, MI
Balti	permit, Perg Department Important: I any Injury o		21. Signature of Funeral Service		1 -	22	Name and Add	Fufferal	118WE;	Helfe	nbei	n, &
			23a. Part 1. Enter the disease, or shock, or heart failure. List	- He fee	the death Do							MD 21617 Approximate Interval Between
	Physiclan /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)	a meta	Due to (or as a	ry	fail	leiomy orc	Dard	ma		yars lays
68760,	tificate be executed ig physician and es the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c							1	0
		Medical	resulting in death) Last	d	Due to (or as a	consequ	enca of):				1	
Вох	death cert e attendin od for use	cian								1	1	
P.O.	thet the de ned by the a detached f	Physician/N	Part II. Other algnificant conditions	des valer		n the und	denying cause g	iven in Part I.	23b. Did			the causs of death? ably 4 Unknown
Records,	requires	Completed by							24a. Was	an autopsy med?	ava	ore autopsy findings allable prior to appletion of cause
Re	The lay	dwc							10	(es 208No		death?
of Vital		Be C	25. Was case referred to medica					26. Place of Dea		1000	' -	Yes 2 No
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Ot	itnatient	3 DOA O		lome 5 Resi		er (Snecifi	()
	er thi		27. Manper of Death	28a. Date of Inju	ry 28b.	Time of	28c. Inju			now injury occur		,
Sior	Attending or deeth. Actor: After by the fune	atio	1 Natural 5 ☐ Pendir investi	gation	y rear)	Injury		Yes 2 No				
Division	al or Atte	Certification:	3 ☐ Suicide 6 ☐ Could determ	28e. Place of fnj building, etc	ury - At home, fa c. (Specify)	ırm, atree	et, factory, office		28f. Location ( City or To		ber or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edicai (	29a. Certifier (Check only one) Certifyin 2 Medical	g Physicien: To the best of Examiner: On the basis of and manner sta	examination an	e, death o	occurred at the t estigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and made and place,	anner as sta and due to	ated. the cause(s)
	To the To the Comp	×	29b. Signature and title of certifie	. /			29c. Licer	se numbar		29d. Date signe	d (Month, L	Day, Year)
			* Kathleer	Hory			DY	7627		9.9-9	7	
			30. Name and address of person						h 1.7	1	0.4	C17
	Cha	10	Dr. Kathleer 31. Date filed (Month, Day, Year)		4U Cen 1 ar's Signature	rrev	TITE F	Rd., Cen	crevil	re, MD	216	617
	Sta Registr				Aulia Davi	dres	Rando 00					
DHI	WH 16 Rev 6/9		V-1	- 1301	1000		- Alexander					



State of Maryland / Department of Health and Mental Hygiene 30692 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** EDWIN REESE RHODES, SR. 3:00Pr 50 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** St. AGNES 1timore HOSPITA Baltimore If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 □MK2□ F Deys 215-01-6584 Yrs. Director 84 Oct.3,1912 Maryland Usuel Residence of Decedent 10e. Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar main be notified at Md. Baltimore 1 ☐ Yes 2000 Director Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 225 Westtown Rd. 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ⊆ ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 Never Merried 2 Narried 1 ☐ Yes XZX No Specify: White by 3 ☐ Widowed 4 ☐ Divorcad permit. Pagas 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiena. Important: (I flem 27 is marked other than "natural", any Injury or other traumatic evant. The Mental "... Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Steel worker Armco Steel 1.0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reese Rhodes Beulah A. Horney 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Hazel Rhodes 225 Westtown Rd.; Baltimore, Md. 21229 Sept. 18, 1997 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) X1X Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Centreville, Md. Chesterfield Cemetery 21. Signeture of Juneral Service Licenses 22. Neme end Address of Fecility Fellows, Helfenbein & Newnam Funeral HOme tentem 106 Shamrock Rd., Chester, Md. 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feilure. List only one gause on each line. **Physician** Preumonia /Medical Immediete Cause (Finel /week disease or condition resulting in deeth) **Examiner** Examiner physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 Effusion, Chronic obstructive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings svelleble prior to completion of cause of death? Palmonury disease, Dehydration 24e. Was an autopsy performed? Dementin 1 Yes 2 DNo 1 ☐ Yes 2 ☐ No this cartificata Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 0 1 Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Aftar 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral DI complataly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. Medicai 29e. Certifier (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated. 29b. Signeture and title of cartifier 29c. License number Resident 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Peattie god Cator Ave, Baltimore, Md. 21229 M. Shannon

**DHMH 16 Bev 6/95** 

State

Registrar

31. Date filed (Month, Dey, Year)

32. Registrar's Signeture

Julia Davidson-Randoll

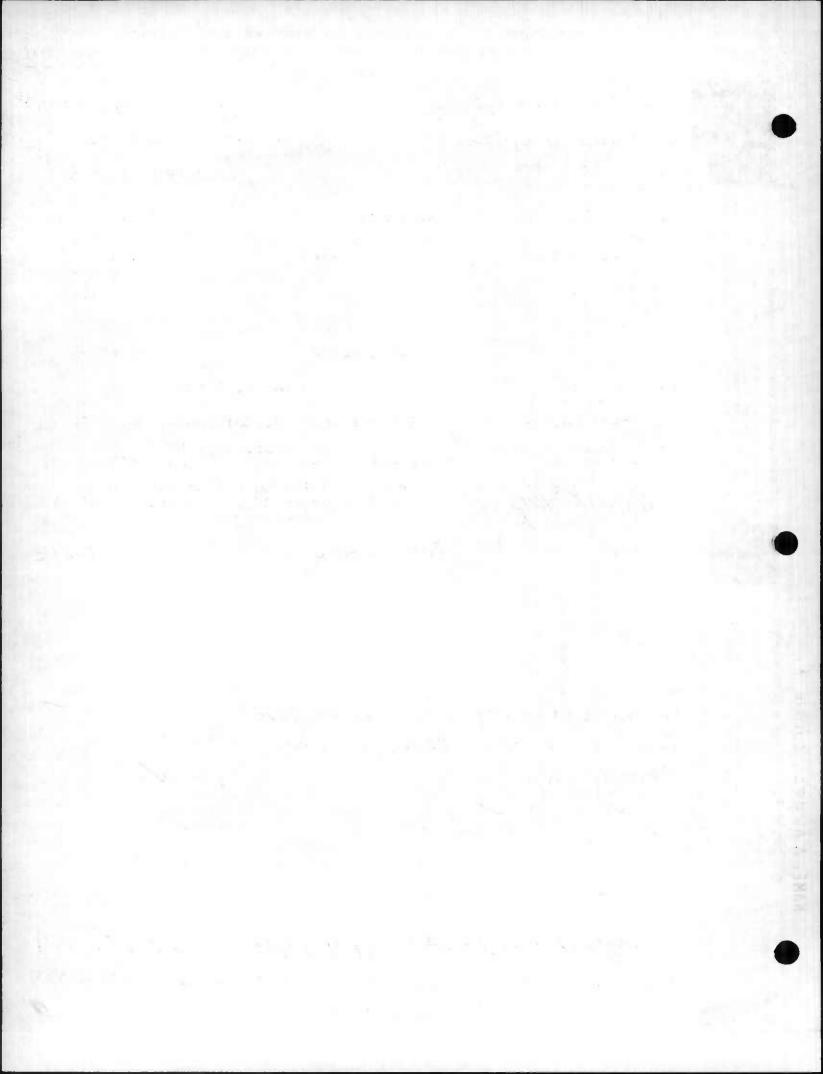
Hospital or Attending | 24 hours after daath.

tha Maryland

Baltimore, Maryland 21215-0020

Box 68760

Edwin



State of Maryland / Department of Health and Mental Hygiene 97

						0	ertificate	OI.	Dealli			Reg. No.			
husisian	1. [	Decedent's Nem	e (First, Middle,	Last)							2. Date of De Month	eath Dey	Year	3. Tim	e of Death
hysician /Medical		Josep	h Kennet	h STONE								28 199		5:30	A.M.
Examiner	4a.	Facility Name (	If not institution,	give street end n	um <i>ber)</i>				4b. City, To		cation of Deat		inty of Death		
	н	Colton	Villa N	Nursing	Cente	r			Hager	stow	n	Was	shingt	on	
ineral	5. 5	Social Security N		S. Sex		yrs. last birthday	Months I	Year	If Under		8. Dete of Bir (Month, De	th			te or Foreigr
rector	7	05-10-5	467	1⊠M 2□ F	8.	3 Yrs.	Sentations C	Juya	noure		April :		4 Pen	nsyl	vania
,		uei Residence of			140	0h 7									
I I	108	I. Stete	10b. County		10	c. City, Town or I	.ocation								e City Limits
Examiner must be notified at by Funeral Director	-	Pa.	Frank]	lin		Chamber	sburg							יטי	/es 2□No
Ole B	100	. Street and Nu	mber				10f. Zip C	ode				10g. Citizen	of What Cou	intry?	
le le		1970 Qu:	igley Dr	ive			172	201				U.	S.A.		
iner must be notified Funeral Director	11.	Maritai Status		12. Was De Armed F	cedent Ever	r in U,S. 13	Was Deceder If Yes, specify	t of H	lispenic Origen. Mexican	gin? (Spe	cify Yes or No Rican, etc.)	)- 14. F	Rece - Amer Bieck, White		١,
1			ied 2 Marrie	d 1 ☐ Yes If Yes, G	2 XNo		1 Yes 2		Specify:				ante		
d by		3 Widowed	4 Divorced	Year or	Detes:							Spe	WI	nite	
Completed		(Spec	15. Decedent's	Education grade completed	()	16a. Dec	edent's Usual ( e <i>ki</i> nd of work o DO NOT use	done	ation during most	of workir	ng	16b. Kind o	f Business/I	ndustry	
du	E	Elementary/Seco	ondary (0-12)		(1-4or 5+)	life.	DO NOT use	retire	d)						
3 0		9		0		Ma	chinist	-					lroad		
Be			(First, Middle, La								(First, Middle		name)		
10		William	Bradfor	d Stone					R	ose S	Shatzei	<u> </u>			
	19	a. informant's No	ame/Rejetionship	(Type, Print)		19b. Mai	ling Address (5	Street	and Numbe	er or Rura	Route Numb	er, City or To	wn, Stete, Z	p Code)	
other traumatic avent, the Manager of the Manager o		Thomas :	r. Stone	, Sr.			Quigle		Drive	Cha	amberst	ourg, I	Pa. 17	201_	
or other tr	20€	. Method of Disp		☐Removel from		Ob. Place of Disp cemetery, cri	osition (Name ametory or othe	of er piad	ca)		Date	20c. Location	on - City or 1	own, State	
6			5 ☐ Other (Spe			Rose Hi	ll Ceme	tei	ry	10	-1-97	Hager	stown	Mar	vland
any injury o	21.	Signature of Eu	nerst Service Lic	tensee	0		22. Neme end	Addre	ss of Facility	y Mir	nnich I	[unera]	Home		-
8			2 RX	1/1 Y	1 m	. 0	415 E.	Wi	lson l			erstown		2174	0
	23	a. Part1. Enter ti	he diseese, or or	emplications that	caused the	deeth. Do not er							.,	Approxi	
se as the burle-transit and WMedical Examiner	Se if a cau	ease or conditional ulting in death) quentially list cony, leading to imuse. Enter Undeuse (Disease or thirting in death) i	nditions, imediate orlying injury		NAL Due	TO (or as a consection of the	equence of):		<i>(10)</i>		WUT <sub>1</sub> (	1/(312}		140	er.
an/Me				d		X								×	
etached for u	Per	t It. Other signif	icant conditions	contributing to	death but no	ot resulting in the	underlying cau	se giv	en in Pert I.		23b. Dld	tobacco use	contributa	to the cau	se of death?
hysi					1/						10	Yss 2□N	o 3 Pro	bebly 4	Unknow
by P	-			Y	ove										
eted	_										24a. Was	an autopsy omed?	a	vailable prompletion	sy findings for to of cause
Comp														death?	
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	25.	Was case reference examiner?	1	Hospitel:				Oth	-	of Death	(Check only	one)			
.0		1 ☐ Yes 2 ☐/		1111		2 ER/Outpatie			4 IZI NU		ne 5 Resi			fy)	
-	97	Mariner of Death	5 Pending		nth, Day Ye			Wor		4	8d. Dascribe	now injury oc	curred		
-	27.	1 Natural		ion	LA	N	7		Yes 2□f		MIL				
-	27.	2 Accident	investigat	be		At home, farm, s	treet, factory, o	ffice		2	8f. Location (	Street and Nu	imber or Rui	al Houte I	lumber,
y the funeral of floation: T	27.			289. Plac	a of tnjury - ding, etc. (Si	pecify)					City or To				
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그 본 본 글 경기를 다 다니는 그 모스  TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Plant it must be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the money. Should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

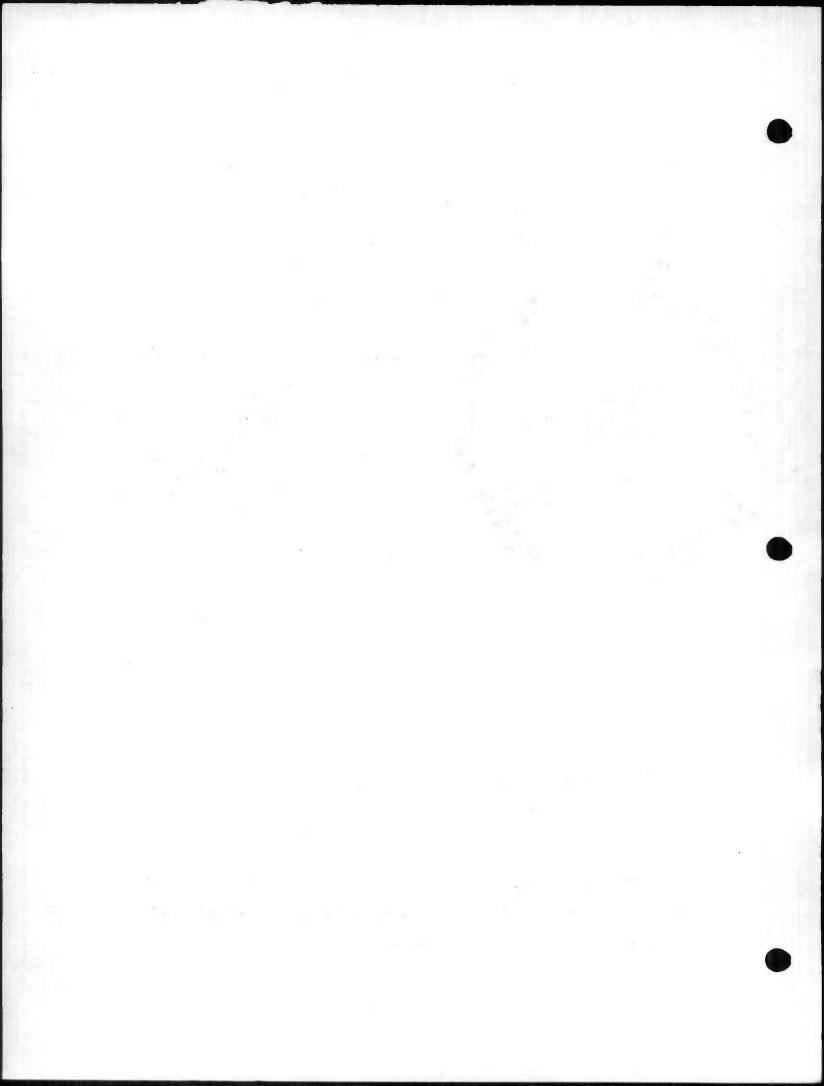
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876d

FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

REGISTRAR		CE	RTIFIC	CATE	F DE	EATH	F	EG. NO.				
1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF				3. TIME OF	DEATN
Marie Catherine	SANDERS						Sept.	27	199	7 YEAR	8:15	a.
4. SOCIAL SECURITY NUMBER	5. SEX 6. A	AGE (In yrs. last .	birthday)	F UNDER 1 YEA	R IF C	INDER 24 HRS.	7. DATE OF	BIRTH		S. BIRTI	IPLACE (State	
213-48-4737	1 M 2 X F	95		ONTHS DAY			Jan. 6	y, Year)	02	Count	w York	
Se. FACILITY NAME (If not institution, give s		sh Dd	9	b. CITY, TOV	Whea	CATION OF D	EATH			MODE		
Randolph Hills-4	JII Kandoli	on Ka.			wnea	LOH			L '	MOHE	gomery	
10a. STATE 10b. COUNT	1		10c. CITY.	TOWN OR LO	CATION						10d. INSIDE	CITY
	tgomery			Kens		ton					LIMITE 1 TES	nknow
4209 Franklin St	reet				10f. ZIP	2089	5		10g. CIT	US	what count A	RY7
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR (	YES 2 K NO		If yes		Cuban, Mexica	NIC ORIGIN? (S an, Puerto Rica y:		or No—	14. RACI Blec Spec	E — American k, White, etc.	
15. DECEDENT'S EDU		16a. DEC	EDENT'S US	SUAL OCCUP	ATION		16b. KII	ID OF BUS	INESS/IN	DUSTRY		
(Specify only highest grade Elementery/Secondary (0-12)	College (1-4 or 5+)	(Giv life. I	e kind of wor Do NOT use	rk done during retired.)	most of i	working						
12	2	b	ookke	eeper			p	harm	aceu	tica.	1	
17. FATNER'S NAME (First, Middle, Last)					18.	MOTNER'S NA	AME (First, Midd	le, Maiden	Surneme)			
John Daly						Bridg	et Mad	diga	n			
19e. INFORMANT'S NAME (Type/Print)			MAILING A	DORESS (Str	eet end No	imber or Rural	Route Number,	City or Tow	n, Stele, Zi	p Code)		
Marie S. Wagner	- daughter						nsingt				5	
200. METHOD OF DISPOSITION		20b. PLACE A					DATE	20c. LO	CATION	City or To	own, State	
1 🔀 Buriel 2 🗆 Cremation 3 🗀 Rem 4 🗆 Donation 6 🗀 Other (Specify)	oval from State	Rest	Have	n Ceme	eter	v 9-	30-97	Hag	erst	own,	Mary1	and
21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE						CILITY MIN				-	
50.011	m			1			Blvd.,					7/10
23. PART I. Enter the diseases, or	1/lens	near									110. 23	-740
IMMEDIATE CAUSE (Finel disease or condition reaulting in death)	DUE TO (OR	AS A CONSECU	UENCE OF):	ly	lac	lerre	2				_	t and Deal
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	с	AS A CONSEO										
that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEO	UENCE OF):									
PART ii. Other significent condition	na contributing to dea	eth but not re	sulting in	the under	iying ce	use given in		PERFOR	RMED?	241	AVAILABLE F	PRIOR TO
											OF DEATN?	2   NO
DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEAT	TH YES	□ NO		JNCERTAI	ND					- 🗀
25. WAS CASE REFERRED TO MEDICAL	1			(Check only								
EXAMINER?	HOSPITAL:	/Outpatient 3		OTHER:	Nome 5	Dpald-co-	6 Other (S	nan/Art				
27. MANNER OF BEATH	28e. DATE OF INJ	URY	26b. TIME	OF 28c	INJURY		28d. DESCR		NJURY OC	CURED		
1 Natural 5 Pending	(Month, Day, Y	bar)	INJUI	RY	WORK?	2 NO	DEGON.			Junes		
2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF IN building, atc.	JURY — At hon (Specify)	ne, ferm, atr	eet, factory,	office		28f. LOCATIO	ON (Street own, State)	and Numbe	er or Rural	Route Number	
enel .	ICIAN: To the best of my										a) and manne	r ae stated.
296. SIGNATURE THE TITLE OF CERTIFIE	Wall,	N.D	),			LICENSE NU 2098	74		•	9/2	9/9 7	>
30. NAME AND ADDRESS OF PERSON WE BARRY ROSENIL	PAUM :	F DEATH (ITEM	27) (Type, F	Print) PRAG	OT	AUG	, Ko	1150	1/6	rou,	,410	2089.
SEP 30 1997	Julia Das	SIGNATURE	indelle	6								



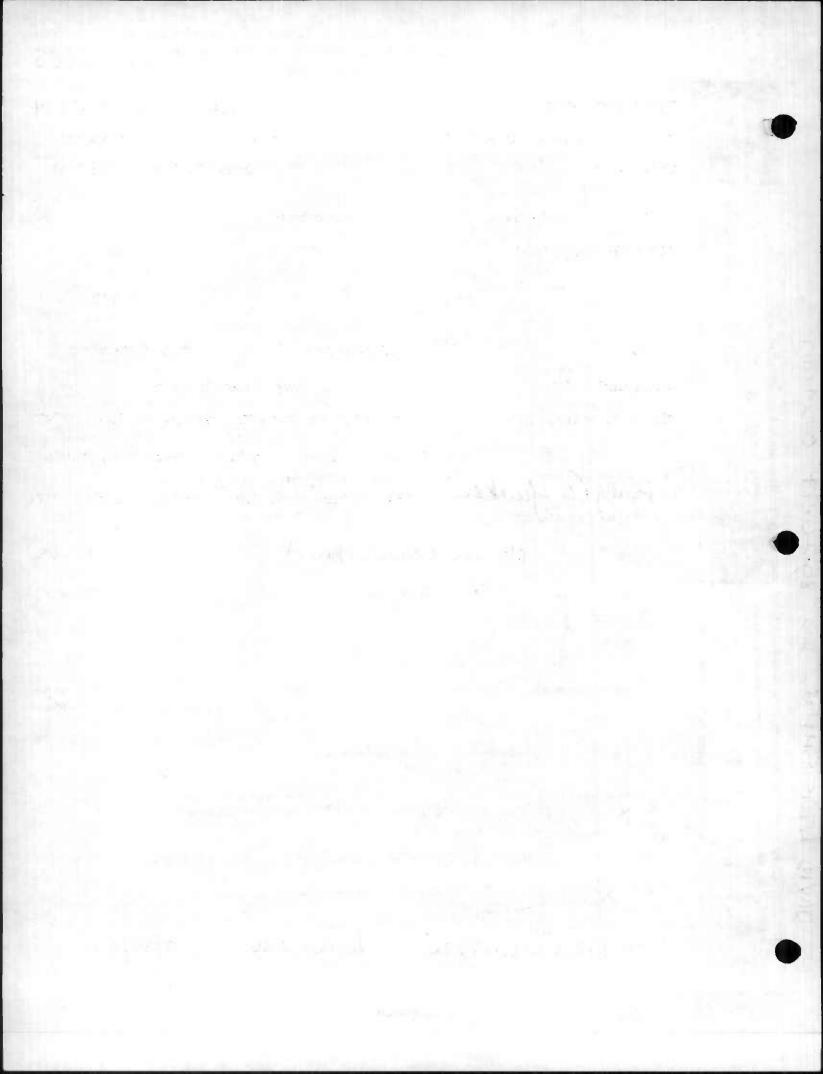
State of Maryland / Department of Health and Mental Hygiene

30695 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Paul James Shollay Sept. 27 1997 11:55 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** 15914 Clarence Pike Drive Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1 MM 2□ F Yrs. Director 66 169-24-4320 June 4,1931 Pennsylvania Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner mant be notified at 10d. Inside City Limits 1 Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 15914 Clarence Pike Drive 21740 USA Funeral 12. Was Decedent Evar In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 star should be liled within 72 hours after 1 X Yes 2 No 1950− If Yes, Give Yaar or Dates: 1952 1 Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 ☒ No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Woodworker Staircase Manufacturer 11 Baltimore, Maryland 17. Fathar's Name (First, Middla, Last) permit. Pages 1 spr2 should be fill.
Depertment of Health and Montal Hy
Important: If Item 27 is marked oth
any injury or other treumetic event 18. Mother's Name (First, Middle, Maiden Surnama) Be Paul James Shollay (Nmi) Julia Kulheimer 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Bessie L. Shollay Wife 15914 Clarence Pike Drive Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Sept.29,1997 Smithsburg,MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Osborne Funeral Home 425 S.Conococheague St. Williamsport, MD 21795 area or complications that ceusad the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, list only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Non-Hodekin's Lymphono 19 month disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Couse (Disease or Injury that Initiated events resulting In death) Last and Dua to (or as a consequence of): the buriel-tre P.O. Box 68760, ed by the attending physician deteched for use as the burie Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. py Completed 24b. Were autopsy findings avellable prior to completion of causa of death? 24a. Was an autopsy performed? certificata has 2 1 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was cese referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No After this in by the funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No 2 Accident after deeth Director: 6 Could not be determined 3 Sulcide 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifier 29c. License number 29d. Date signad (Month, Day, Year) 1. Melowal 041667 9. 79.97 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Campus Rd. Svide 130 threeshown MO 21742 Michael J. McCornack 11110 31. Date filed (Month, Day, Year) State SEP 29 1997 Registrar

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medica Examine		4a. Fecility Nama (If not institution, give					4b. City, Town, or			of Death	04.2
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and sh	010	MD Wash:	ington			Hage	rstown				1 □ Yas Z
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27 is me		19e. Informant's Name/Ralationship (7) Gladys A. Smith,					and Number or Auge Road,				
ner of Herm	2	20a. Method of Disposition  12 Burial 2 Cramation 3 1  4 Donation 5 Other (Specify,			Disposition (Ne y, cramatory or Haven C			Date	20c. Location		wn, Stata Maryla
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/Medical xaminer		Immediata Causa (Final disaase or condition rasulting in death)	. Massiv				rest				minute
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ettending physicia for use as the bur	N. W.	resulting in daath) Last	d	(							
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he ettendir	5 F	Part II. Other significant conditions co	ntributing to death but	not rasulting in	the underlying	causa giv	van in Part I.	23b. Did 1	obacco uee co	ntribute to	the cause of d
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended item 19b & 20b per F.D. State of Maryland / Department of Health and Mental Hygiene 30697 9/26/97 Carroll Co. p.1.c. Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 24 GALEN KEMP STONESIFER Sept. 1997 3:50 p.m. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Eldercare Sykesville Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Month Day, Year) Jan. 1, 1921 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** Months Days 17 M 2□ F Maryland 219-12-2220 76 Yrs Director Usuei Residence of Decedent the Maryland 10e Stete 10b. Count 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at No 2 No Director MD Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 13 Frederick Street 21787 U.S.A Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 72 hours after 1 Yes 2 □ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: specify: Caucasian þ WW II 3 ☑ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Department of Health and Mentel Hygiene. Important Hitem 27 is marked other than "n any Injury or other traumatic event, I'm Meas Eiemantary/Secondary (0-12) College (1-4or 5+) Laborer Rubber Shoe Manu. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumama) Be Edgar LeRoy Stonesifer Sadie Lucretia 2 19b. Meiling Address (Straat and Number or Rurel Route Number, City or Town, State, Zip Code)
P.O. 21787

Taneytown, MD 21787 19e. Informent's Neme/Relationship (Type, Print) Roland Stonesifer, Brother 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State Baust Cemetery 9/27 Tyrone, Maryland 4 ☐ Donetlon 5 ☐ Other (Specify) 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral Service Licensee Stilles 136 E. Baltimore St., Taneytown, MD 21787 M00534 Enter the diseasa, or complications that caused the deeth. Do not anter the mode of dylng, such as cardiac or raspiratory errest, or haart fallure. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in death) Examiner Examiner C 10 burial-transit Sequentielly list conditions, if eny, leeding to immediate causa. Enter Underlying Cause (Diseese or Injury that initieted events resulting in daath) Lest and Due to (or es e consequence of) Records, P.O. Box 68760, attending physician for use es the buria 8 Physician/Medical Due to (or as a consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by t d be datect 1 Yes 2 Ne 3 Probably 4 Unknown þ 24b. Were eutopsy findings evallable prior to Completed 24a. Wes en eutopsy performad? peen completion of cause of daeth? page 2 this certificate has 1 Yes 2 HO 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 1 Yes 2 No To the Hospital or Attanding Ph within 24 hours aftar death. To the Funeral Director: After th completaly filled in by the funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending Invastigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicida 1 Settifying Physician: To the bast of my knowledge, death occurred et tha tima, date and place, and due to the ceusa(s) end manner es steted.

2 Medical Examiner: On the basts of axeminetion end/or invastigation, in my opinion, death occurred et the time, date end place, and due to the causa(s) end mennar stated. Medical 29a. Cartifier 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of cartifier 29c. Licanse number

State Registrar

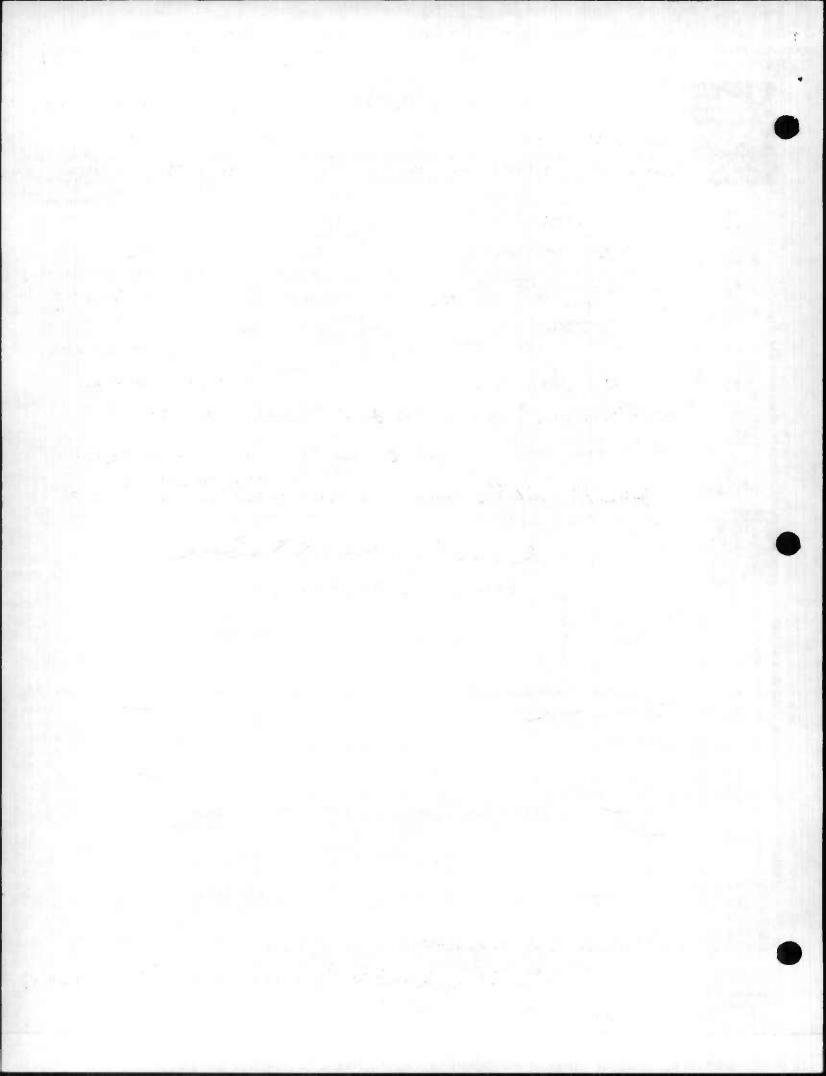
istrar SEP 2 6 1997

30. Neme end address of person with

31. Date filed (Month, Dey, Year)

32. Registrar's Signatura

of death (Itam 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item 17, per F.D. State of Maryland / Department of Health and Mental Hygiene 9/26/97, Carroll County, wil Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Dey 2035 Hugh McMichael Sweeney 24, 1997 Sept. /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Carroll County General Hospital Westminster Carroll If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M M 2 □ F Yrs. Director 200-09-2213 Nov. 17, 1919 Pennsylvania Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at MD Director 1 ☐ Yes 2 1 No Carrol1 Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 2210 Snydersburg Rd. 21157 United States 238 Funeral Herns 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck White etc should be filed within 72 hours efter nd Mentel Hygiene. marked other than "natural", or Ne 1 Never Married 2 Married 1 Ves 2 No If Yes, Give Yeer or Detes: WWII Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Salesman Commercial Kitchen permit. Peges 1 and 2 should be file Department of Meath and Mentel Hy Important of I feen 27 is marked other any lightry or other traumatic evant. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Edward Everett Raymond Sweeney Elizabeth McMichael 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Marguerite Sweeney, wife 2210 Snydersburg Rd., Westminster, MD 20b. Pieca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 09/27/97 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Dulaney Valley Cemetery Cockeysville, MD 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Home & Chapel 412 Washington Rd., Westminster, MD 21157 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physiclan** HNOXIC ENCEPHALOPATHY /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Preumonia 175 PIRADON sician and burial-trensit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) physician s the burial Box 68760. Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. been signed by the should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 3 Probably 4 Unknown ANTORUSEPHIL MYDDARDIAL INFARCTION Records, þ 24e. Wes en eutopsy performed? evelleble prior to completion of cause of deeth? Completed NOW INSULM DEPENDENT DIABETES 24b. Were eutopsy findings evelleble prior to ete has MELLI TUS Division of Vital Hospital or Attanding Physician: 24 hours after death. Puneral Director: After this certificately filled in by the funeral director, p Be 25. Was case referred to medical 26. Plece of Death (Check only one) 1 Yes 2 No Hospitel: 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Deeth Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end manner stated. To the Hosp within 24 hou To the Fune completely fil 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

31. Dete filed (Month, Dey, Year)

HOMAS GALVIN MO SEP 2 6 1997

30. Name and eddress of person who completed cause of deeth (item 23a) (Type, Print)

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STONER AVENUE

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 20b, 9/25/97, Per F.D., Carroll County, wil Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month September 21, 1997 Marguerite 11:00 a.m. /Medical 4a. Fecility Name (If not institution, give streat and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Nov. 25, 1 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthdey) Birthplace (State or Foraign Country) **Funeral** 1□M 2XXF Yrs. 185-14-2056 81 Director 1915 Pennsylvania Usual Residence of Decedent the Meryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 2 Yas 2 □ No Director Maryland Frederick Woodsboro 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò Rems 23e 201 S. Main St. 21798 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of from and Mental Hygiene.

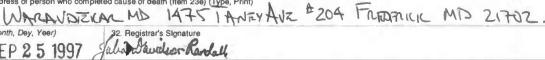
pir II hem 27 is marked other than "naturel", or items 23 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Merriad 2 Married 21215-0020 1 ☐ Yes 2 ☒ No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grede Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Frank Cannon Catherine (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Charles Shuty/ husband 201 S. Main St. Woodsboro, MD 21798 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, State permit. Pages Department of Importage If the eny Injury or o AlTegnenya Cemetery 9/24/97 Butler St. Pittsburgh, 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State Mary's Catholic Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licenses 22. Name and Addrass of Facility Hartzler Funeral Home Woodsboro, MD 23a. Part1. Enter the disease, or complications that caused the math. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onsat and Death **Physician** 2 MONTHS /Medicai Immediate Ceusa (Final disease or condition resulting in death) MALIGNANT MESOTHEUMA Examiner Due to (or es a consequence of): Examiner The law requires that the death certificate be executed nding physician and use as the burial-transi Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760. Physician/Medicai Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by d be detec 1 Yes 2 No 3 Probably Qunknown Division of Vital Records. by been sig 24b. Wara eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 Yas 2 No certificate Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Chack only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA this funeral Certification: 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending Investigation 1 Natural ours efter death. death. 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide ŏ To the Hospital of within 24 hours of To the Funeral D completely filled 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) and manner as stated.

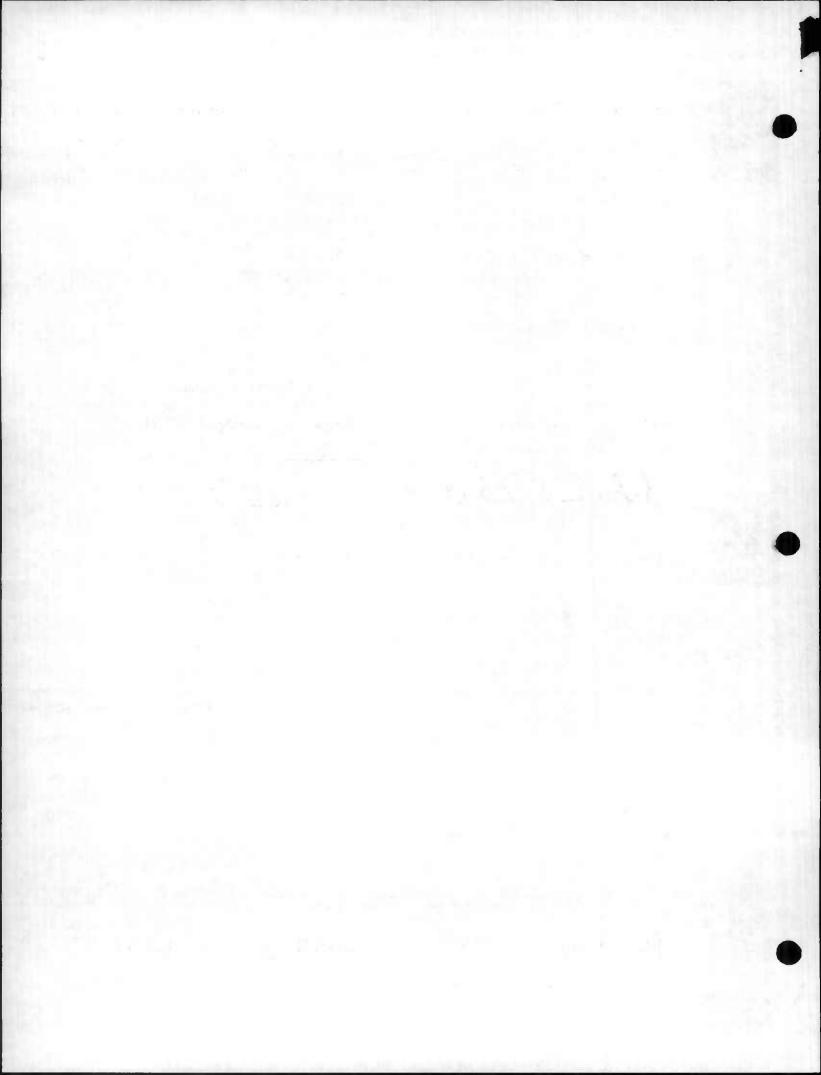
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medical 29b. Siggature and title of certifier 29c. License number 29d. Data signed (Month, Dey, Yaer)

State Registrar 31. Date filed (Month, Dey, Yeer) SEP 2 5 1997

Warun

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)





State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 30700

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sician	Decedent's Nama (First, Middle	e, Last)						2. Dete of De Month	eeth Dev	Year	3. Time of Deeth
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ai	5. Sociel Security Number	6. Sax	7. Aga (In yrs. I	ast birthday,			ndar 24 Hrs.	8. Dete of Bi	rth		plece (Stefe or Forai
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	10e. Stete 10b. County		10c. City	, Town or L	ocation						10d. Inside City Limit
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Director	10e. Streef and Number				10f. Zip Co	de			10g. Citizen of	Whet Cou	ntry?
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ner	11. Meritel Status	12. Was Dec	edent Evar In U.S	5. 13.	Wes Decedent	of Hispani	lc Origin? (Sp	pacify Yes or No Rican, etc.)		ce - Ameri	can Indian,
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									per, City or Town		code)
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3	D ( athania	00	lande.	2	2. Name and A	ddress of F	IIa.		Funeral	Home	
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State Registrar 31. Dete filed (Month, Day, Yeer)

SEP 2 5 1997

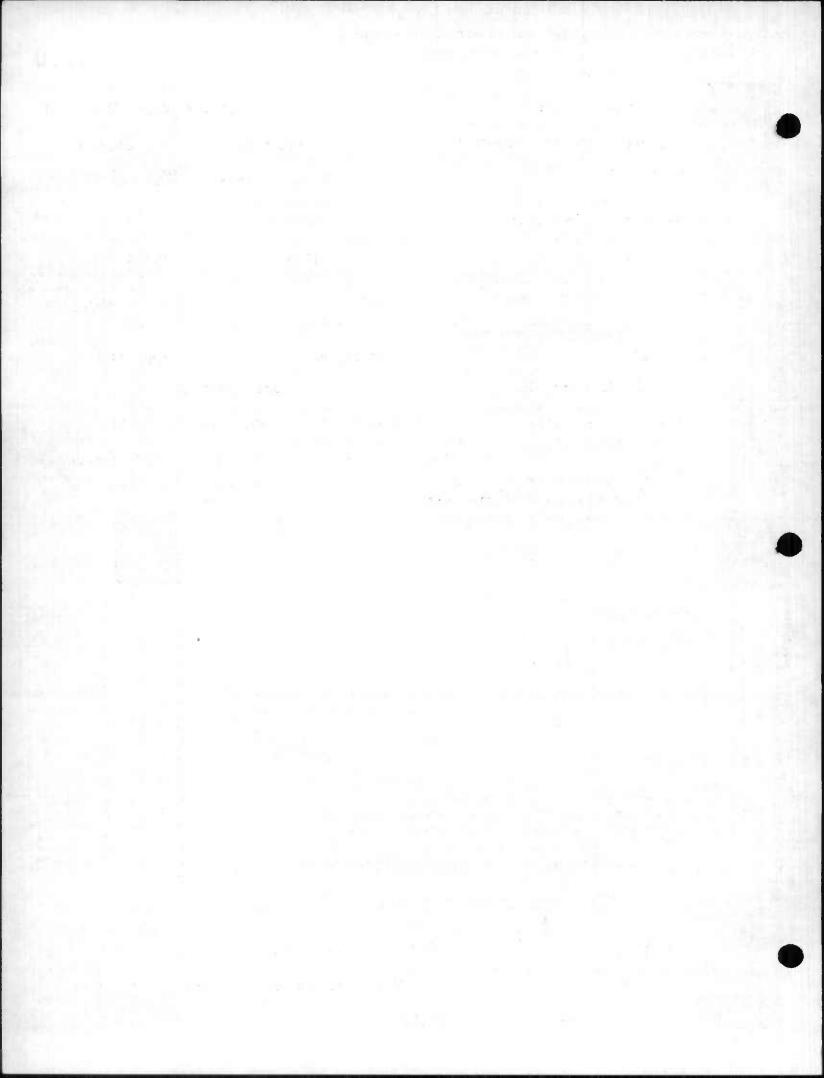
Joseph Ashwal

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

56 Thomas Johnson Dr.

Frederick, MD 21701

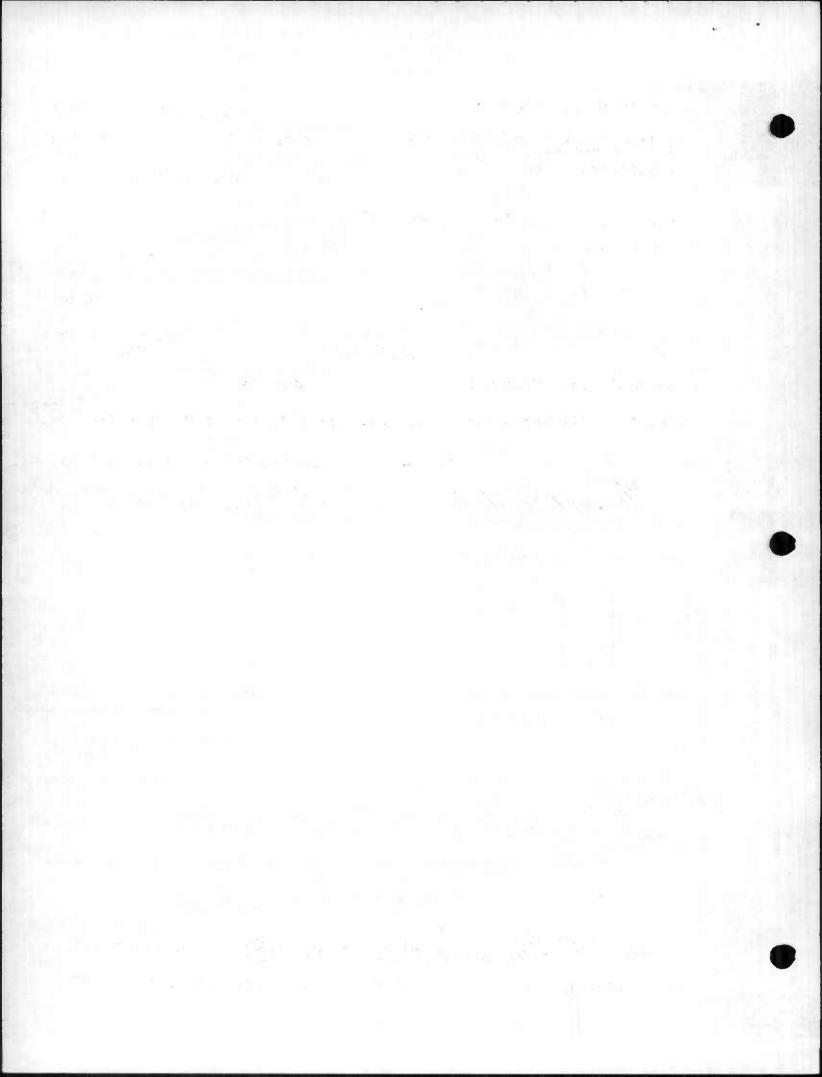


State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Year Benjamin C. Tilghman 19:10 Sept.
4b. City, Town, or Location of Deeth 1,1997 /Medical 4a. Facility Nama (If not institution, give street end number) 4c. County of Death Examiner Genesis Eldercare- Meridian of Queen Anne's Centreville Corsica Hills
5. Social Security Number 6. Sex If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** XIXM 2□ F 180-18-7791 Yrs. Director Penn. June 30,1917 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic svent, the Madical Examinar must be notified at Centreville 1 ☐ Yes 2 CINo Director Md. Queen Anne's the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 Hermitage Farm Home 21617 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit.—Parges 1 and 2 should be flied within 72 hours after c Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or ites any Injury or other traumatic svent, the Medical Examina 1 Never Married A Married 1 ∀es 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: P White 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Houten Mifflin & Elementary/Secondary (0-12) Coilege (1-4or 5+) Co. Publisher 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Lisa Fox Benjamin Chew Tilghman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant'a Name/Relationship (Type, Print) 21617 120 Hermitage Farm Lane, Centreville, Md. Mrs. Anna Tilghman- Wife Sept. Dete 2, 1997 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 1 ☐ Bunai 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center Stevensville, Md. 21. Signature of Funeral Service Licensee, 22. Neme end Address of Facility Fellows, Helfenbein & Newnam Funeral HOme 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 408 S. Liberty St., Centreville, Md. 21617 Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) . STAPHYLOCOCCUS AUREUS SEPSIS Examiner ROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and P.O. Box 68760, Physician/Medical the Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MYELD DYSPLASIA signed I Records. þ 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an eutopsy pertormed? Completed 1 Yas BUNO Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica complately filled in by the funeral director; 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Suursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yas 2 No 10 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Sept. 2,1997 30. Name and address of person who completed/cause of death (Item 23a) (Type, Print) Eric Ciganek, M.D.; 2540 Centreville Rd., Centreville, Md. 21617 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State Julia Spiridran-Randoll Registrar

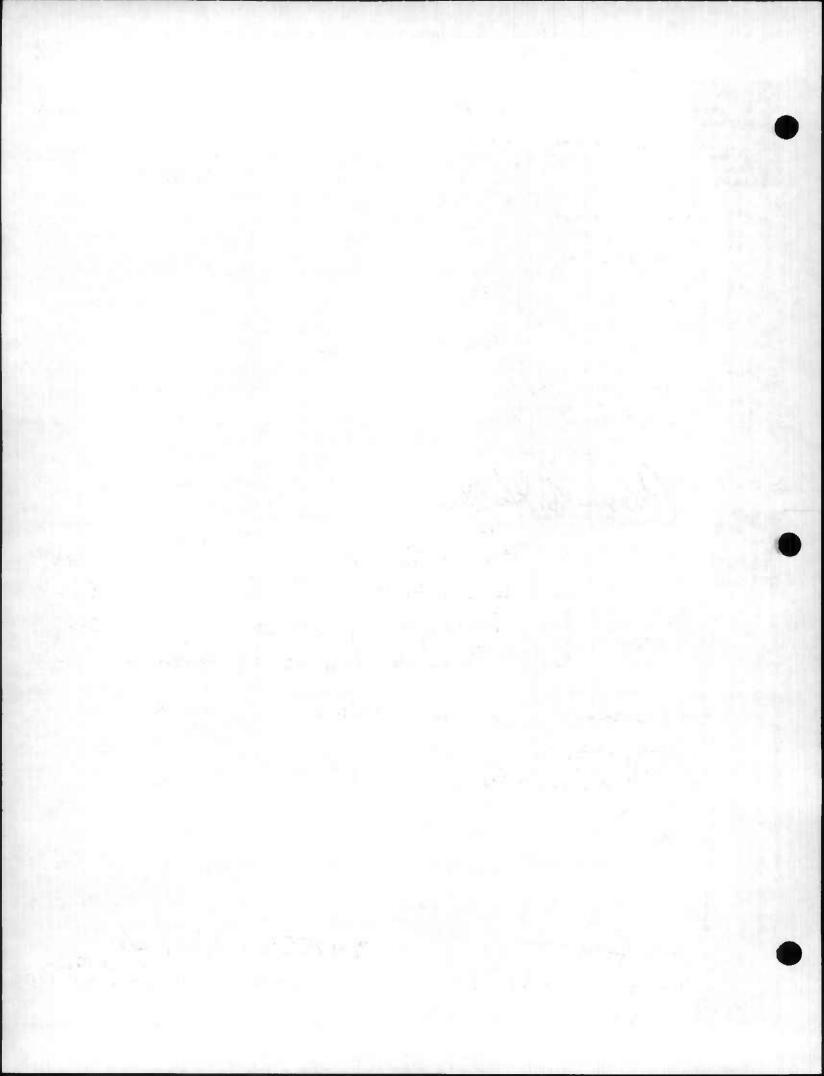
**DHMH 16 Rav 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 30702

				C	ertificate of	Death	R	eg. No.		
		Decedent's Neme (First, Middle, Las	t)				2. Dete of Dea	th	V	3. Time of Deeth
Physi /Med		DIANE MAI	TREGO	VING			Septemb	er 23,	1997	1:44 PM
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	,	Frederick Memoria				Frederi		Frede	erick	
Funera Directo	_	5. Social Security Number  454-64-2090  Usuel Residence of Decedent	TM 200 F	In yrs. lest birthd Yrs	Months Days			Yeer)		ece (Stete or Foreign ny) land
death with the Maryland rms 23a or 28a-f show r insist be not fred at		10a. Stete 10b. County	1	0c. City, Town o	Location				10	d. inside City Limits
Ma-f	ctor	Maryland Frederic	k	New Man	cket					1 ☐ Yes 2 1 No
or 28	Director	10e. Street end Number			10f. Zip Code		1	0g. Citizen of V	Vhet Count	ry?
23a		12107 Lime Plant	Rd.		2177	74		U.S	S.A.	
- in # 8	by Funeral	11. Maritel Stetus  1 □ Never Married 2 □ Married  3 ₺ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Yeer or Detes:	er in U,S.	Was Decedent of If Yes, specify Cu     □ Yes 2 No.		Specify Yes or No- rto Rican, etc.)		e - America k, White, e	
5-0 2 ho	ted	15. Decadent's Ed		18a. De	cedent's Usuel Occu	petion	-1.e	16b. Kind of Bu		
215	Completed	(Specify only highest green Elementery/Secondery (0-12)	College (1-4or 5+)	(G	ive kind of work done		orking			
filed with Hygiene, the ont, the	Con				Homemak	er		0	wn Ho	me
Tal Hall Hall	Be	17. Fether's Neme (First, Middle, Last)				18. Mother's Na	me (First, Middle, I	Maiden Sumem	e)	
Marylan 12 should be n end Mental is marked of reumatic eve	2	Orin Woodrow Ki					la Rebecc			
end 2 sh path end n 27 is m		19e. Informent's Name/Relationship (7 Angel R. Tregonia	ng/ daughte	r 12	ailing Address (Stree 2107 Lime					
Baltimore, Maryland 21215-0020 permit. Pages 1 and 22-bodid be filed within 72 hours at Department of Hearth and Mental Hygiene. Important: Hitem 27 is marked other than "natural", or any injury or other traumetic event, the Medical Example.		20e. Method of Disposition  1   Burial 2 □ Cremetion 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, o	sposition (Name of cremetory or other plane) Meth. Ce	metery	Dete 9/26/97	20c. Location nr New Lon		
Balt permit. Depart Importa		21. Signature of Funerei Service Licen	J. Santo	1	22. Neme end Addi		ctzler Fu		ome	
		234 Part Enter the disease, or comp	licetions thet caused th	e deeth. Do not	enter the mode of dy					Approximete
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V E E 0	an/Medical	resulting In deeth) Lest	1)	e to (or as a cons	le III	0 ch	died In	furcti	in	2 days
O. E	Physician	Pert II. Other significant conditions co	ntributing to deeth but r	of resulting in the	e underlying cause g	iven in Pert I.	23b. Dld to	bacco use con	tribute to	the cause of death?
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es the	b	Davier		THI.	20 (00)10					
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of Vital Re Physician: The in rithis certificate ha and director, page	Be	25. Wes case referred to medical examiner?					eth (Check only on	Θ)		
of hysic this c	2	ILI TES ZIZMO	Hospitel: 1. Unpatient	2□ ER/Outpa	tient 3LJ DOA		Home 5 ☐ Reside			
Division of Vital Records, to Attending Physician: The law requires the effect death.  Director: After this certificate has been signe in by the funeral director, page 2 should be e	ation	27. Menner of Deeth  1. Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Y	ear) 28b. Time Injur	y Wo	uryet ork? ]Yes 2∐No	28d. Describe ho	w Injury occurr	ed	
Division  Division  The of Attending selection  The office of the position of the position  The office of the position of the position  The office of the position of the posi	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (		street, fectory, office		28f. Location (St City or Town	reet end Numbe n, Stete)	er or Rurel	Route Number,
Division o  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)	elclan: To the best of m ner: On the besis of ex end menner stated	emination end/or	eth occurred et the t investigation, in my	ime, dete end place opinion, deeth occi	e, end due to the courred et the time, d	euse(s) end me ete end plece, a	nner es sta and due to	ited. the cause(s)
To t With To to	M	29b. Signeture and title of certifier				7556		9d. Date signed	(Mother), D	ley, Yeer)
		30. Name and address of person who c	empleted cause of deet	h (Item 23e) (Typ	no Print)		NSIVDNI	YI FR	ENE	1702 WICH MD
	ate	31. Dete filed (Month, Day, Year)	22. Registrer's	Signeture	, , , , , ,	- 14 4 - 1	.,,	-)	,	
Regis	rar	SEP 2 5 1997	your areas	wer hand	4,					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #24a Per Phy G755 1/14/98 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** Harold Veasel 31, Aug. 1997 /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 108 South Carolina Rd. Stevensville Queen Anne's If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) 6. Sex Birthplece (State or Foreign Country) Months XXM 2DF 215-22-3499 71 Yrs. Feb. 4,1926 Maryland Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Md. Queen Anne's Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 S. Carolina Rd. 21666 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritei Stetus 14. Race - American Indien, 1 ☐ Never Married ※ Married 1 ☐ Yes X2 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Koppers Co. Elementery/Secondery (0-12) Coilege (1-4or 5+) Heat treat operator 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be George Zaccheous Veasel Mary Lillian Downs 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Harold L. Veasel, Son 6 Kimberly Ct., Stevensville, Md. 21666 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete Chesapeake Cremation Center Stevensville, Md. 1 ☐ Buriel 2 € remetion 3 ☐ Removei from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service-Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home Lyoman concur 106 Shamrock Rd., Chester, Md. 21619 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Non-small cell lung Caner Immediete Cause (Finel disease or condition resulting in deeth) 14 aunte Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ٥ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Menner of Deeth Certification: 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide

Examiner attending physician and for use as the buriel-transit The law requires that the death certificate be executed Box 68760, P.O. the been signed by Division of Vital Records, has certificate or Attending Physician: After this deeth. Director: n 24 hours after dee we Funeral Director pletely filled in by th To the I

**Funeral** 

Director

r than "natural", or itema 23a or 28a-f show the Medical Exampler reset be notified at

72 hours after deeth with the Maryland

filed within 7 I Hygiene.

other than

permit. Peges 1 and 2 should be file Deportment of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event since.

**Physician** 

/Medical

Baltimore, Maryland 21215-0020

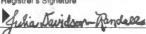
State Registrar

Medical

29a. Certified (Check only one)

29b. Signeture and title of cartifier

30. Name and moress of person who completed cause of death (Item 23e) (Type, Print)



David H. Smith, M.D.: 509 Idlewild Ave. Easton, Md. 21601
31. Deterflied (Month, Dey, Yeer) | 32. Registrer's Signeture

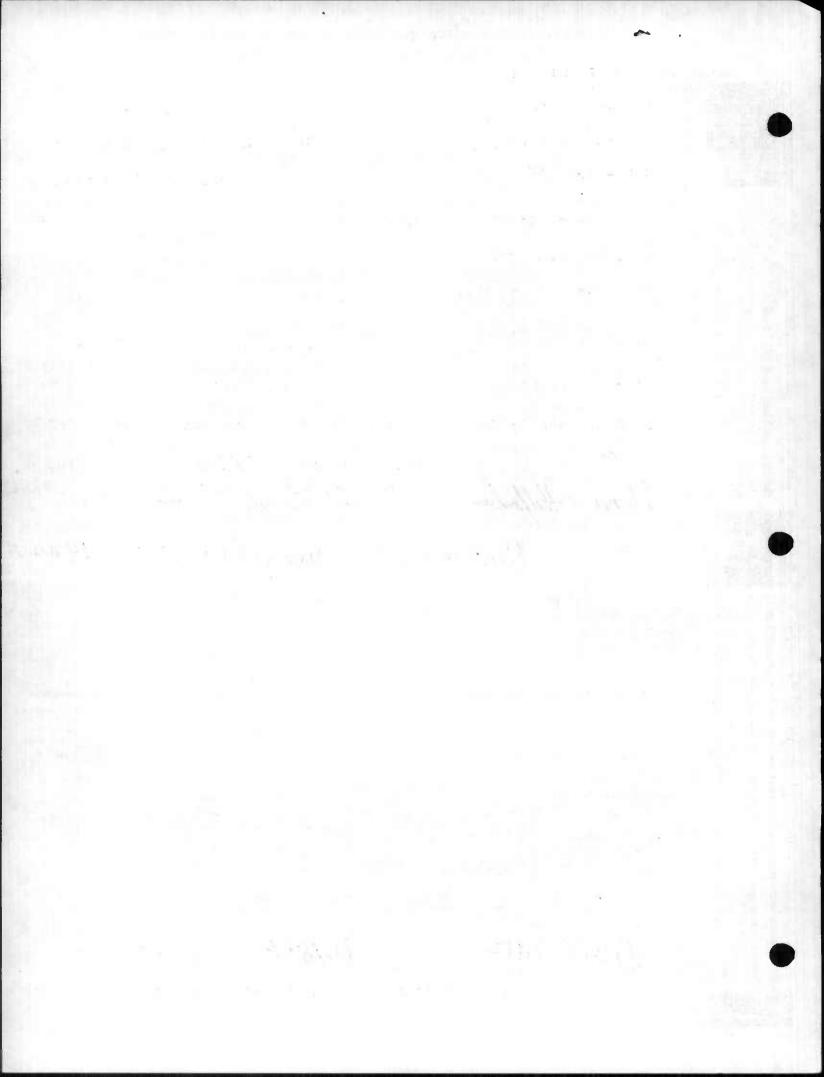
1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner steted.

29c. License number

29d. Date signed (Month, Dev. Year) Sept. 2,1997

**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene 97

20701

					Centi	ificate o	t Death		Reg. No.		
sician		s Name (First, Midd						2. Date of I	Death Day	Year	3. Time of Death
edical		ry Eugene						SEPT.		1997	5:15AM
miner			on, give street end numb		OTT ON	73 F	4b. City, Tov	vn, or Location of De		ounty of Death	
ral	18800 5. Social Sec	ROXBURY curity Number	ROAD-TRAIN	AND CORRE	thday)	If Under 1 Yea				ASHING"	The second secon
tor	218-	62-9068	1,X) M 2□ F	30 °	Yrs.	Months Day	ys Hours	Min. Dec.	,1986	Ma	nplace (Stete or Foreign untry) Lyland
		ence of Decedent		10. 0: 7							
by Funeral Director	10a. State	10b. County		10c. City, Tow							10d. Inside City Limits
Director	Md.		shington	Saba	llas	ville					1 ☐ Yes 2 No
Sire	10e. Street a	nd Number				10f. Zip Code	9		10g. Citize	n of What Cou	untry?
		37 Mt. Zi	on Ra.			21	780		и	I.S.A.	
Funerai	11, Maritel St	latus	12. Was Decede Armed Force	nt Ever in U,S.	13. Wa	s Decedent o	of Hispenic Orig	in? (Specify Yes or I Puerto Rican, etc.)	Vo- 14	. Race - Amer	
by Fu	1	r Married 2 Mar	ried 1 ☐ Yes 2] If Yes, Give	X No		Yes 2X N		Puerto Fican, etc.)		Black, White	hite
Q P		wed 4 Divorce	Year or Date	S:							
15. Decadent's Ed (Specify only highest green Elementary/Secondary (0-12)		est grede completed)	16a.	(Give kin	nd of work don	cupation ne during most ired)	of working	160. Kind	of Business/I	naustry	
ф	Elementary		College (1-4d	or 5+)	me. DO	Labor			Con	struct	ion Co.
Eugene E. Willar		Last)		-		_	's Name (First, Midd	lle, Maiden Su	ameme)		
		llard				Sus	an L. Gar	denhou	vr		
-	19a. Informe	nt's Name/Relation	ship (Type, Print)	19b	. Mailing /	Address (Stre	et and Number	r or Rural Route Num	ber. City or T	own, State, Z	ip Code)
	Euge	ene E. Wi	llard liath					Sabillas			1780
		of Disposition	. 0	20b. Place of	Dispositi	on (Name of		Date	1	tion - City or T	Town, State
5		at 2 Cremation tion 5 Other (5	3 □Remeval from Sta	Sethel		of on the p		,1997		ade, Md	
once.		of Funerei Service		becher			dress of Facility		_		
once	4	ternis i	Cotav		Dav	is Fun	eral 110	me Smiths	burg, M	ry Ave ld. 217	83
	23a. Pert1. E shock,	Enter the disease, o or heart failure. Lis	r complications that caus t only one cause on each	sed the death. Do not line.	not enter t	the mode of d	lying, such as c	ardiac or respiratory	arrest,		Approximate Interval Between
an				<i>i</i> \							Onset end Death
ai er	Immediate C disease or co	ondition		10	100	1/109				11	
	resulting in d	eath)	a	Due to (or as a	conseque	rice ot):				- 1	
ine											
edical Examiner	Sequentially	list conditions,		Due to (or as a	conseque	nce ot):				T	
Ü	cause. Enter	list conditions, g to immediate r Underlying								4	
edical	that Initiated resulting in d	events eath) Last	0	Due to (or as a c	onsequer	nce of):				1	
100			d								
ian			0							İ	
Physician/N	Part II. Other	significant conditi	ons contributing to death	but not resulting in	the unde	erlying cause	given In Part I.	23b. Di	d tobacco us	e contribute	to the cause of death?
								1[	Yes 2	No 3□Pro	obably 4 Unknown
b									/ \		
ted								24a. Wa	as an autopsy rlormed?	a	Vere eutopsy findings vallable prior to
Completed						-					ompletion of cause f death?
0								1	Yes 201	No 1	Yes 2□ No
(0)											

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Division of

XX Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Wish 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) nd Number or Rural Route Number

(Check on

Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E SEPT. 27, 1997

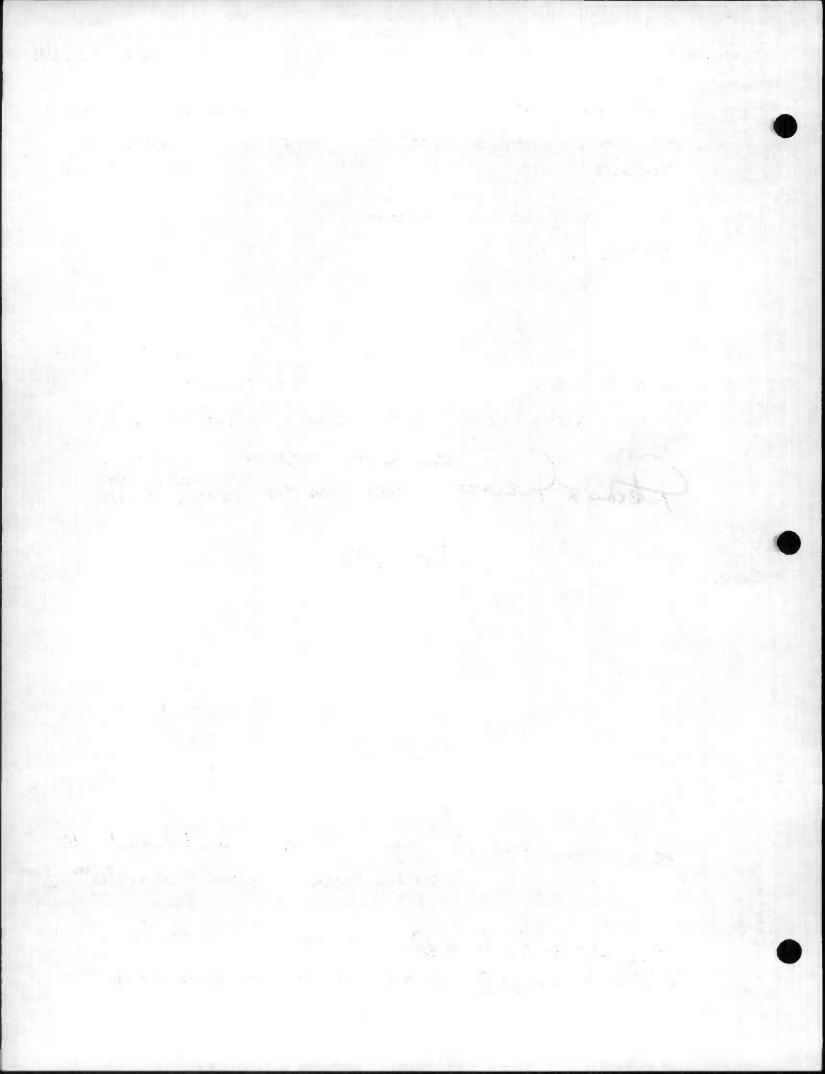
e of person who completed cause of death (Item 23a) (Type, Print) Locke

111 Penn Street, Baltimore, Maryland 21201

State Registrar

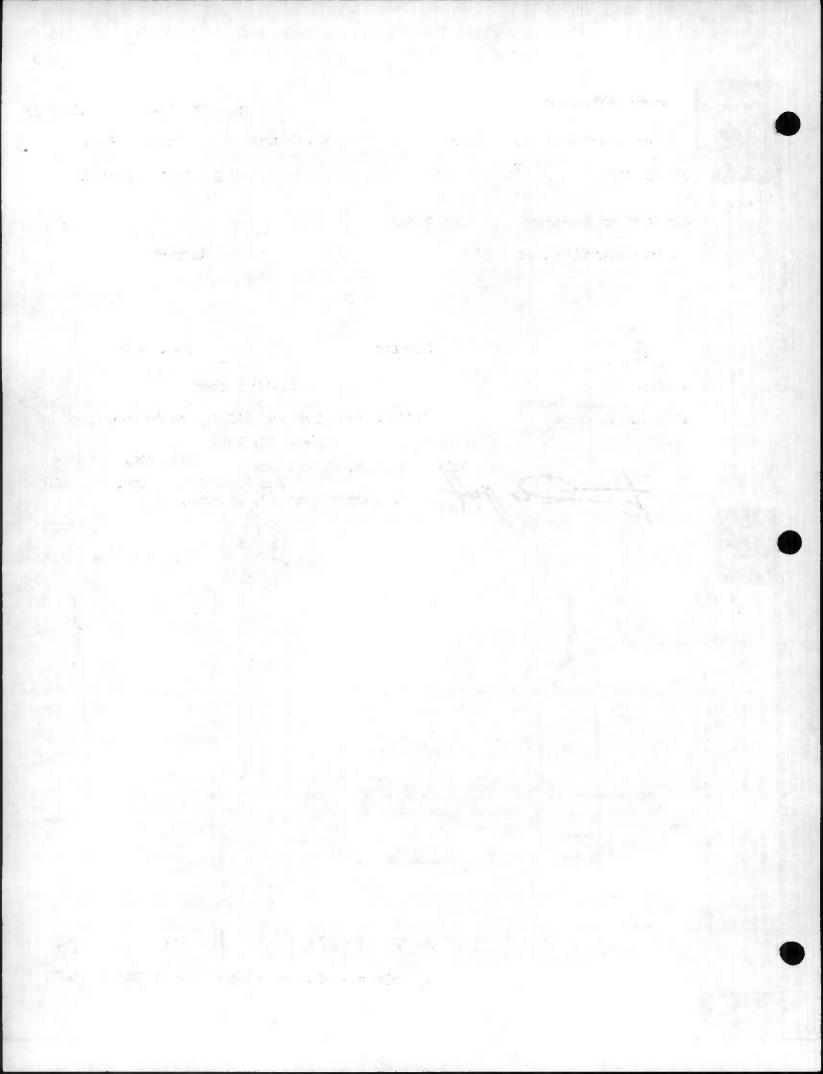
Medical Certification:

32. Regittal's Signature



State of Maryland / Department of Health and Mental Hygiene 97 30705

					Cei	rtificat	e of	Death			Reg. No.		00100
Physic		Decedant's Name (First, Middla, I Renate Whitehe			- 1					2. Data of Da Month	nath Day	Yaar	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, g	iva straat end number,	)				4b. City, To	wn, or Lo	cation of Deat	25, 1997 h 4c. Count	y of Death	10:00 AM
Lauin		10505 Cedarvill	e Road # 1	1329			]	Brandy	wine	9	Princ	e Geo	orge
Funera Directo	_	5. Social Security Number 6. 577 66 4248 Usual Residence of Decedent	Sex 1 □ M 2 ▼ 7. A	ga (In yrs. lest i	virthdey) Yrs.	If Undar Months			24 Hrs. Min.		th ay, Yaer)	9. Births	placa (State or Foreign ntry)
rland me	1	10a. State 10b. County		10c. City, To	wn or Lo	cation						1	IOd. Inside City Limits
far death with the Marylan freme 23s or 28s-f show	Director	Maryland Prince (	George	Brand	ywin	e 10f. Zip	Code				10g. Citizen of	What Cou	1 Yes 2 No
aath with s 23a or must be		10505 Cedarville	1		10.1		206		-1-0 (0-		Germany		
15-0020 In 72 hours after death with the Maryland "natural", or items 23s or 28s-f show tedical Examinar inval be notified at	by Funeral	11. Maritai Status  1 Never Marriad 2 Married  XX Widowed 4 Divorced	12. Was Decedent Armed Forces  1  Yas 2  If Yes, Give Year or Dates:	?		f Yes, spec		an, Mexicar Specify:	gin? (Spo n, Puarto	ecify Yas or No Rican, etc.)	Special	ce - Amaric ck, White, fy: W	
5-C	etec	15. Decedent's (Specify only highest of	Education reda complated)	16	a. Decad	dent's Usua kind of wo	al Occup	oation during mos	t of work	ina	16b. Kind of E	Businass/in	dustry
212 with ione. there	Completed	Elementery/Secondery (0-12)	College (1-4or	5+) C	'life. t 'ashi		se retire	during mos d)			Woolwo	orth	
yland 2 ould be filed Mental Hygid arked other ettic event, ti	To Be C	17. Fathar's Nama (First, Middla, Lat UNKNOWN	(1)							(First, Middle N Becke	, Meidan Sumai Y	ma)	
Mar nd 2 sho alth and 27 Is m		19e. Informant's Name/Relationship John H. Whitehea									er, City or Town Brandy		code) 20613 Maryland
Pagas 1 a nant of Haz		20a. Method of Disposition  ADA Burial 2 Cremation 3 4 Donation 5 Other (Spec								<b>19</b> 97	20c. Location Arlingt		
Baltimos permit. Pagas Department of Important: If it any Injury or once.		21. Signature of Funeral Sarvice Lic	D. H	Arino	oton 22	Natl Name an	ona.	L Ceme	Lee	Funera	1 Home, on, Md	Inc.	irginia 6633 Old
Physician /Medical Examiner		23a. Part 1. Entar tha disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)		State	o not ente	er the mod	e of dyl	ng, such as				-	Approximate Interval Between Onsat and Death
BOX 68760, aath certificata be axecuted attending physician and for usa as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b	Due to (or as a									
- O 65 %	Physician	Part II. Other significant conditions	contributing to death b	ut not resulting	In the ur	nderlying c	ause gh	ren in Part I		23b. Did	tobacco use co	ontribute to	the cause of death?
										10	Yes 2□ No	3 Proi	bably W Unknown
aw requires been 2 should	Completed by										an autopsy ormed?	av co	ere autopsy findings sliable prior to mpletion of cause death?
# 4	Con									10	Yes 2 No	10	Yes 2 No
r VITAL I yslcien: Th s cartificata director, pag	Be (	25. Wes case referred to medical axaminer?						26. Place	of Death	(Check only	one)		
- 2 w 5	2	1 Yes 2 No	Hospital: 1 Inpatie		utpatien	t 3□ DO	A Oth	er: 4 Nu	rsing Hor	ma 5 Resi	dence 6 □Oth	ner (Specif	(v)
Ing P	ion:	27. Manner of Death YE Natural 5 Pending	28a. Date of Inju (Month, De	y Year) 28b.	Time of Injury	M 2	8c. Injur Wor			28d. Describa	how Injury occur	rred	
DIVISION OF To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not determined	28e. Place of Inj	ury - At home, to. (Specify)	iarm, atre			Yas 2□(		28f. Location ( City or To	Street end Numi wn, Stete)	ber or Rura	al Route Number,
To the Hospital or A within 24 hours after To the Funeral Dire complately filled in b	edical C	29a. Certifier (Check only one)  29a. Certifying P  Certifying P  Certifying P  Certifying P	hyalcian: To the best of	O A A I I II I O I I O I	je, death nd/or inv	occurred a	at the tir	ne, date en pinion, deat	d plece, a	and due to the ed at the time,	cause(s) and m date and placa,	anner as s	tated. the ceuse(s)
o the omple	Z G	29b. Signature and title of cartifier	and manner sta	ateu.		290	. Licans	a number	/		29d. Date signe	ed (Month,	Dey, Year)
- 5 - 0		Junoth	5 Acm	m 1	10	3	28	22 (	1	1~	26	Sept	- 97
		30. Name and address of person who	Swyer	MI	(Type, F	elter	Ree	ed Arm	y Me	dical	Center,	Wash	ingtonDC
Sta Regist	_	31. Data filed (Month, Dey, Year) SEP 3 0 1	32. Registr	ar's Signature	Rand	all							



BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL BECORDS P.O. BOX 13146

האבווייייייייייייייייייייייייייייייייייי	n 24 hours after them. Figure 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by me were direction and solved by detached for use as the burial-transit permit. Pages 1, 2, 3 should	abon, of remine	other traumatic event, the medical examinar must be notified at once.
DIVISION OF VITAL RECORDS, F.C. BOX 13149,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours and the first 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completel	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buna, cremation, or remine	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

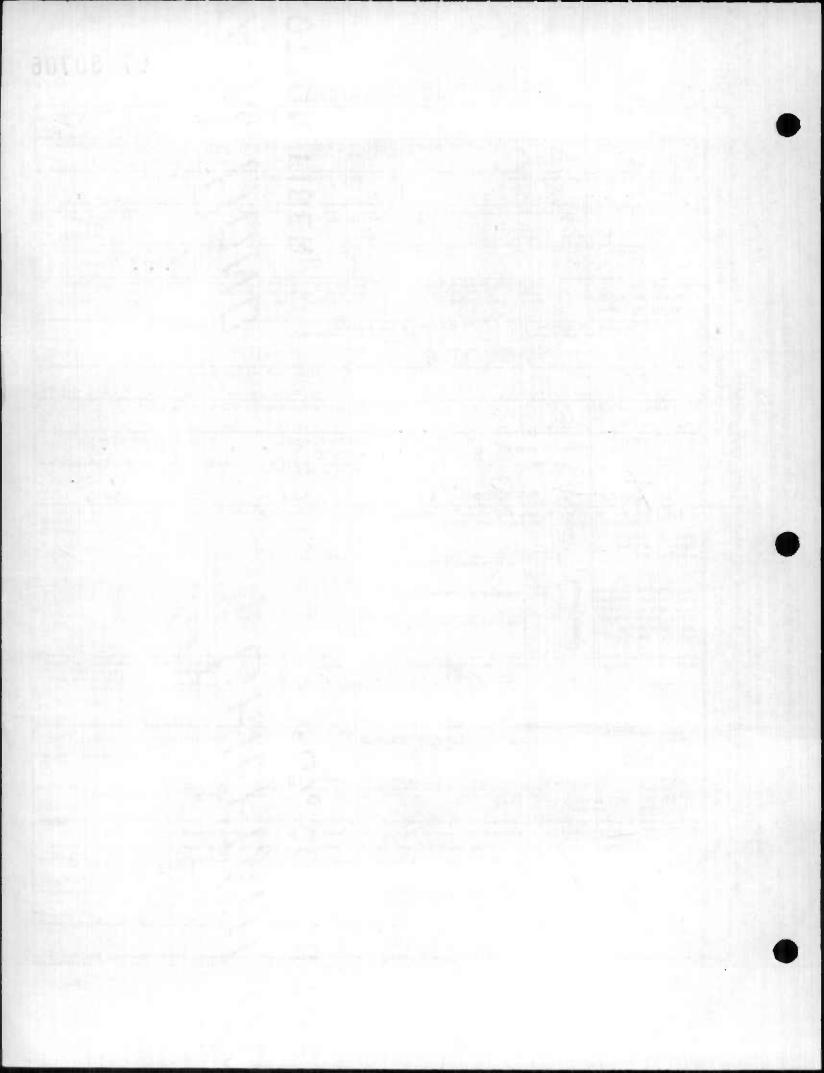
REGISTRAR  1. DECEDENT'S NAME (First, Middle, Lest)	11	CERTIFI	CATE OF DEATH	REG. NO		3. TIME OF DEATH
Margaret	Nay	lur C	Nard	Sign terroe	8 19	YEAR 10 3 AM
4. SOCIAL SECURITY, NUMBER 156	8. SEX 8. AGE	(In yrs. lest birthday)	F UNDER 1 YEAR F UNDER 24 HRS. MONTHE DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 18.1		BIRTHPLACE (State or Foreign Country)  Mary Jand
9a. FACILITY NAME (If not institution, give atm			9b. CITY, TOWH OR LOCATION OF		9c. COUNT	Y OF DEATH
10316 Piscataway	Road		Clinton		Princ	ce George's
Maryland Prince	George's		town or location inton			10d. INSIDE CITY LIMITS?  1 YES 2XXNO
10316 Piscataway	Road		101. ZIP CODE 20735		U.S.	A.
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FDRCES? 1 YES IF YES, GIVE WAR OR D	2 NO	13. WAS DECENDENT OF HISP If yes, specify Cuben, Mexi 1 TYES 2	cen, Puerto Rican, atc.)	s or No— 14	4. RACE — American Indian, Black, White, atc.
15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 8 +)	(Give kind of w life. Do NOT use		16b. KIND OF BU	JSINESS/INDUS	STRY
8th  17. FATHER'S NAME (First, Middle, Lest)	N/A	Homemak		HOME NAME (First, Middle, Malder		
	los es els ess d					
Harry Navlor T	(Cousin)	19b. MAILING	ADDRESS (Street and Number or Run	a Perry F		
Franklin A. Robin	son Tr	PO	Box 305 Bened	ict Maryla	nd 200	512
20a METHOD OF DISPOSITION 1 X Burlel 2 □ Cremation 3 □ Remo	20	b. PLACE OF DISPOS	ITION (Name of cometery, crematery,	5t 30 20c, L		ty on Town, State
4 Donation 6 Other (Specify)	Wall from State We	after the sale of				
		esuluitsc	er Cemetery Se	97 Wes		
21. SIGNATURE OF FINERAL SERVICE LICE		Hall-		97 Wes	tminic	ster Maryland
21. SIGNATURE OF FONERAL SERVICE LICE		70/K	22. NAME AND ADDRESS OF	97 Wes	tminic uneral	Home, Inc.
23. PART I. Enter the diseases, or co	On piloations that charge	d the death. Do n	22. NAME AND ADDRESS OF	97 Wes FACILITY Lee Fu xandria Fer	tminic neral ry Rd	ster Maryland Home, Inc. Clinton, MD20
23. PART I. Enter the diseases, or c shock, or heart failure. I	On piloations that charge	d the death. Do n	22. NAME AND ADDRESS OF 6633 Old Ale: ot enter the mode of dying, a	FACILITY Lee Fuxandria Feruch as cardiac or response	tminic neral ry Rd	Home, Inc. Clinton, MD20  Approximate interval Batween
23. PART I. Enter the diseases, or c shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition	On piloations that charge	d the death. Do n	22. NAME AND ADDRESS OF 6633 Old Ale: ot enter the mode of dying, a	97 Wes FACILITY Lee Fu xandria Fer	tminic neral ry Rd	Home, Inc. Clinton, MD20  Approximate interval Batween
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23. PART I. Enter the diseases, or coshock, or heart failure. It immediate CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other significant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES SONO  27. MANNER OF DEATH  1 Netural 6 Pending	DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS	A CONSEQUENCE OF	22. NAME AND ADDRESS OF 6633 Old Ale: ot enter the mode of dying, and the underlying cause given  28. PLACE OF DEATH OTHER: 4 □ Nursing Home 5 President	In Part I. 24a. WAS A PERFC  Check only one)  De 6 Other (Specify)	n Autopsy	ter Maryland Home, Inc. Clinton, MD20  st, Approximate interval Batweer Onset and Deatl  24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
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23. PART I. Enter the diseases, or c shock, or heart failure. It immediate cause or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions or conditions of the condition of the cause of the conditions of the cause of the caus	DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  DUE TO (OR AS  E contributing to death	a consequence of a cons	28. PLACE OF DEATH  28. PLACE OF DEATH  OTHER: 4   Nursing Home   Page dent  28. PLACE OF DEATH  OTHER: 4   Nursing Home   Page dent  WORKY M   1   PTES   2   No	In Part I. 24a. WAS A PERFC 1 YES  Check only one)  284. LOCATION Since City or XWm, Stet	NAUTOPSY PRIMED?	Approximate interval Batweer Onset and Deatl Prior To COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  JRED

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

enc

32. REGISTRAR'S SIGNATURE
Julia d'Aurelser Reveall 31. DATE FILED (Month, Day, Year) SEP 3 0 1997

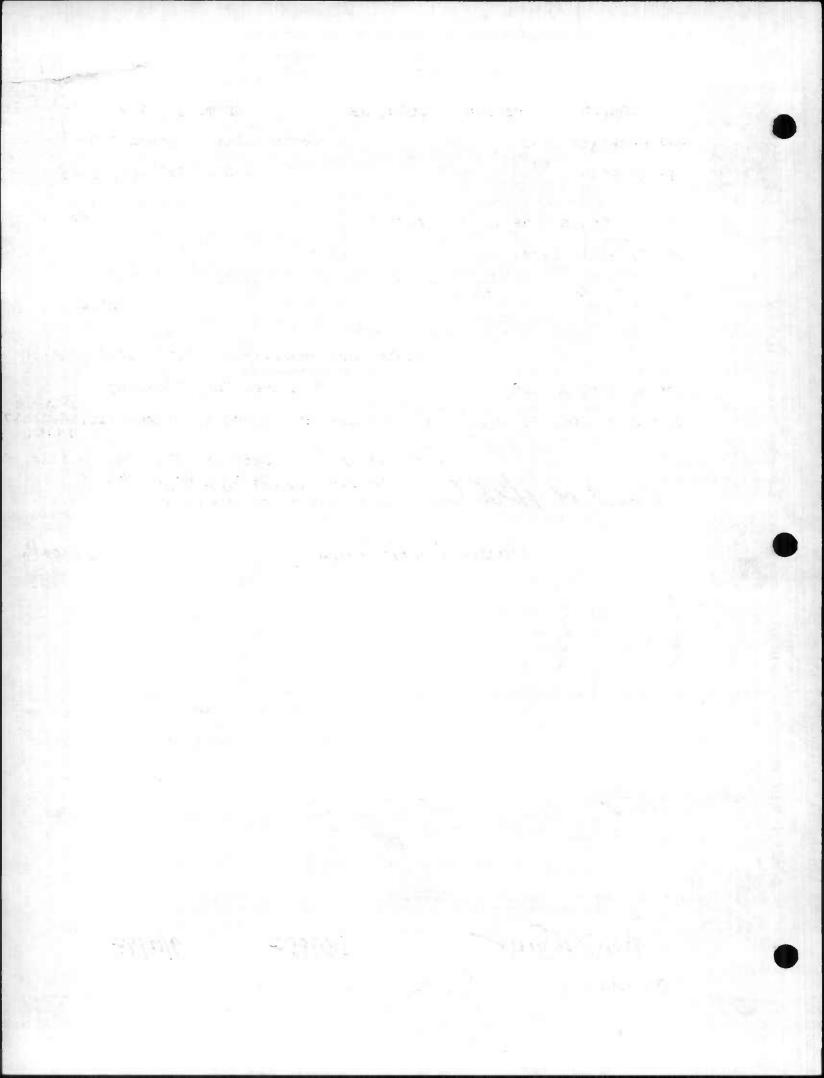
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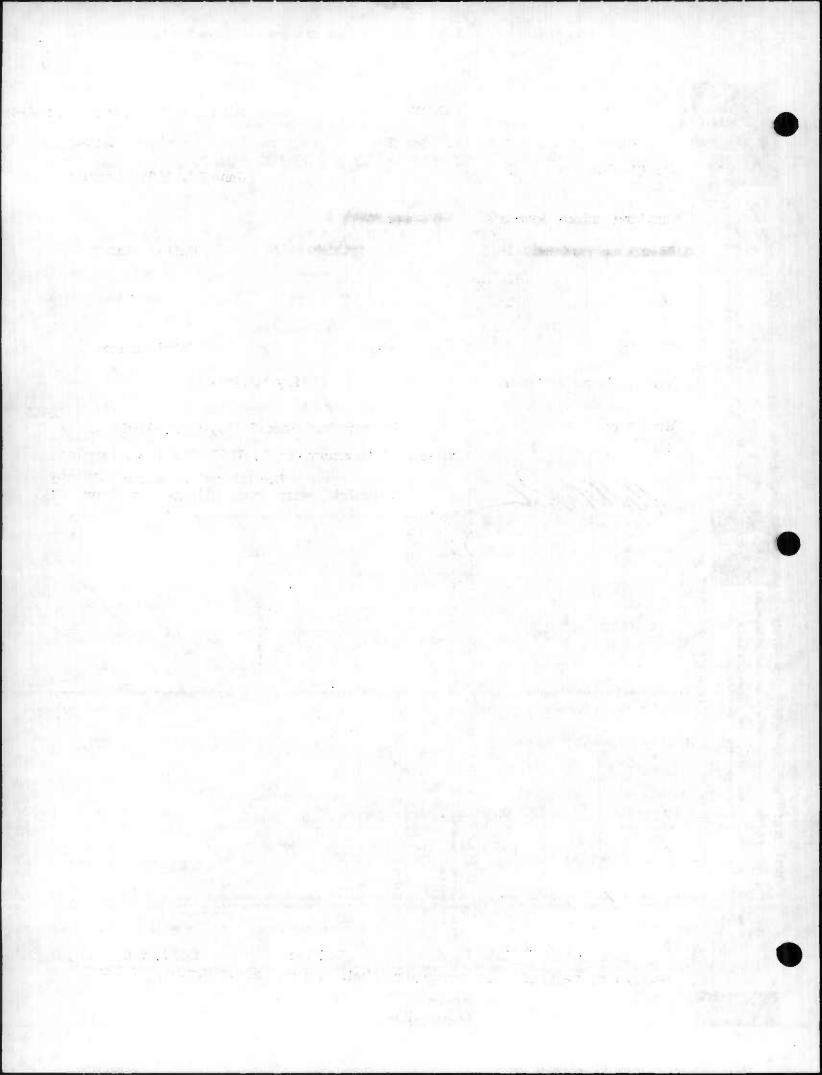
State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:20 p.m. 11, JOSEPH HASTON WOOD, JR. SEPT. 1997 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Centreville Oueen Anne's 607 Carville Lane H Under 1 Yaar | H Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. Jan. 24, 1925 5. Social Security Number 6. Sex. 1⊞M 2□ F 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 72 Yrs 213-22-5180 Director Maryland Uauai Residenca of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inaide City Limita 7 is marked other than "natural", or items 23s or 28a-f show traumatic svent, the Medical Examinar must be notified at XXYes 2 No Director Centreville Md. Queen Anne's 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 21617 U.S.A. 607 Carville Lane permit. Peges 1 and 2 should be filled within 72 hours after death 1 Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or team any injury or other traument. Funeral 12. Was Decedent Ever In U,S. Armed Forcas?
1 ☐ Yes ※ No If Yas, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: White à ff Yas, Give Year or Datas: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life - DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Board of Education 12 Maintenence Supervisor 17. Father's Name (First, Middle, Last) 18. Mothar'a Nama (First, Middle, Maidan Surname) Florence Jane Breeding Joseph Haston Wood, Sr. 2 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 202 Baytree Rd.Apt.202-A, Centreville, Md.2161 Joseph H. Wood III/Son 20c. Location - City or Town, Stafa 20b. Placa of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State Sept. 15, 1997 Centreville, Md 4 ☐ Donation 5 ☐ Other (Specify) Chesterfield 21. Signature of Funeral Sarvice Licensae 22. Name and Address of Facility Fellows, Helfenbein, & S.Liberty St., Centreville, Md. 21617 408 23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Caccurria o Immediata Cause (Final disease or condition resulting in death) 5 month /Medical Examiner physician and s the burial-transit requires that the daeth certificata be axecuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Dua to (or as a consequence of): attending 980 20 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findinga available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen has pege 2 1 Tyes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours aftar death. To the Funeral Director: After this certifica director. Be 25. Was case raferred to medical axaminar? 26. Place of Death (Check only ona) Hoapital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes 2 No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 2 4 Homloide 29a. Certifler 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to tha cause(s) and mannar as stated. Medical pletaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifier 29c. License number 2 29d. Datersigned (Month, Day, Year) 97 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Idlewild 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rav 6/95

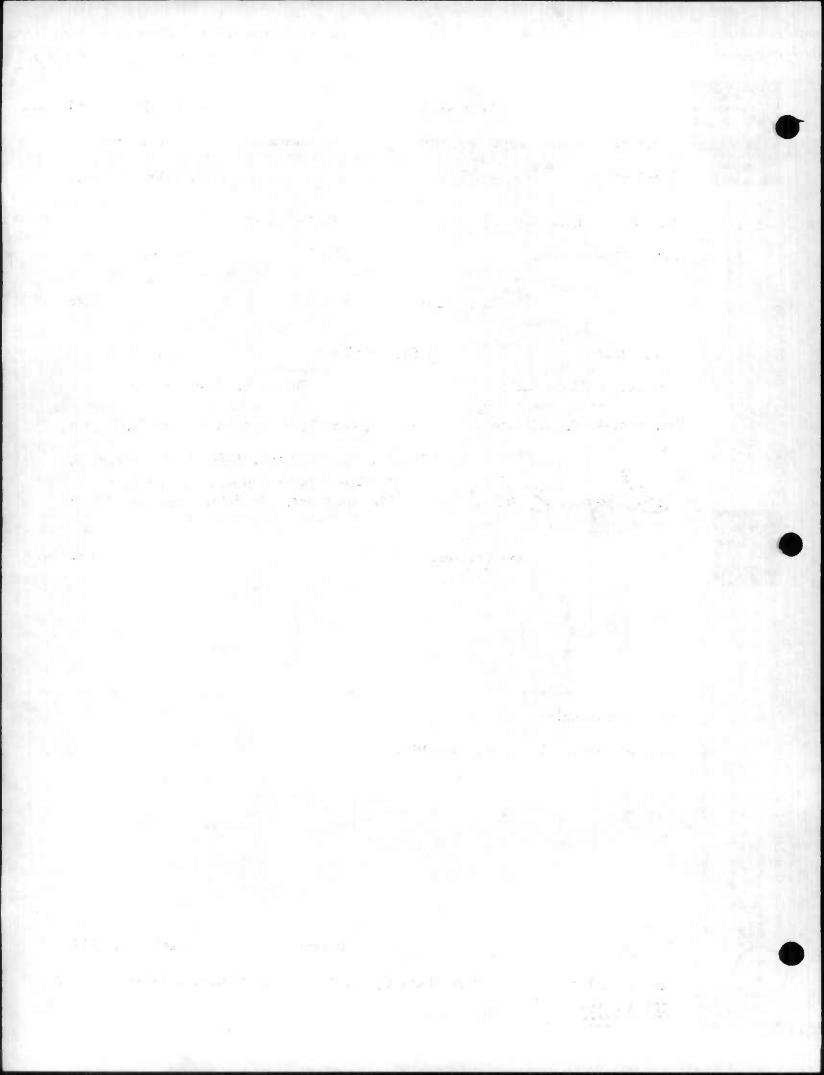


	1. Dece	dent's Name (First, Mid	dle, Last)		- 77	Certi	ficate of	Death	2. Date of D	Reg. No.	3. Time of De
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iner	4a. Feci	PRINCE GE	-	-		CENTER		4b. City, Town, o		,	of Death OF GEORGES
1	5. Socie 23	Sacurity Number 9-01-9126	6. Sax			lest birthdey)	f Under 1 Yaar Aonths Days		8. Deta of B	lirth Dey, Yaer)	9. Birthplece (Steta or Fi Country) Virginia
	Usuel R	esidenca of Decedent te 10b. Count	tv		10c. Ci	ity, Town or Locat	ion				10d. Insida City L
to	Max	yland Prin		eorge's		Mitchell					1 Yes 2
Funeral Director		eet end Number 50 Lottsfor	rd Rd	. L1-18		Tyre!	10f. Zip Code 207	721-2734		10g. Citizen of V United	
by	10	tal Status  Never Marriad 2 Ma  Widowed 4 Divorce	urried	2. Was Decede Armed Force 1 Yes 2 If Yes, Give Yeer or Data	s? No	If Ye	s Decedent of I as, specify Cub I Yes XX No	dispanic Origin? ( en, Mexican, Pua Specify:	Specify Yes or North Rican, atc.)	Blac	ea - Amarican Indian, ck, Whita, etc. White
eted		15. Decede (Specify only high	ent's Educi	ation	- 15	16a. Deceden	t's Usuel Occup	pation during most of wid)	orkina	16b. Kind of Bu	usiness/industry
Be Completed		ntery/Secondery (0-12)		Coilege (1-4c	or 5+)	Sale	NOT use retire	d)	UKUIG	Retail	Clerk
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Examiner		in deeth)	b.	HYF	PERTE	or as a consequer				J.	AND MAN
Exa	if eny, le	ielly list conditions, eding to Immediate Enter Underlying Disease or Injury			0) 0) 600	or es a consequer	ica or).			1/00	N. V.
an/Medical	filet luiti	oted avants In deeth) Lest	d.		Due to (c	or as e consequen	ica of):			Janua	harry
Physician/M	Pert II. C	ther significant condit	lons contr	ibuting to death	but not res	sulting in the unde	rlying cause giv	ven in Pert I.	23b. Dic	tobacco uee cor	ntribute to the cause of d
		FRACTURED	LEF	T HIP	(SUE	BCAPITA	L FRAC	TURE)	10	Yee 2□ No	3 Probably 4 Uni
Completed by	-	SEVERE OS	TEOP	OROSIS	5				24e. We	s en eutopsy formed?	24b. Ware eutopsy findi evelleble prior to completion of caus of deeth?
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Be	exap	case referred to medic		spitel:			l Out		eth (Check only	one)	
1: To	27. Man	/es 2 □ No er of Deeth	110	28e. Dete of In	jury	ER/Outpatient :	3 DOA Oth	4 U Nursing		how Injury occurr	
Certification:	- 0	100100111	tigation	(Month, E	Jay Year)	06:00P		k? Yes 2 No			LL AT HOME
the		Sulcide 6 Could determined control could	I not be mined	28e. Plece of I building,	njury - At he etc. (Specif	ome, ferm, street,		-1.0 -	28f. Location City or To		er or Rural Route Number,
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State of Maryland / Department of Health and Mental Hygiene 97 30709

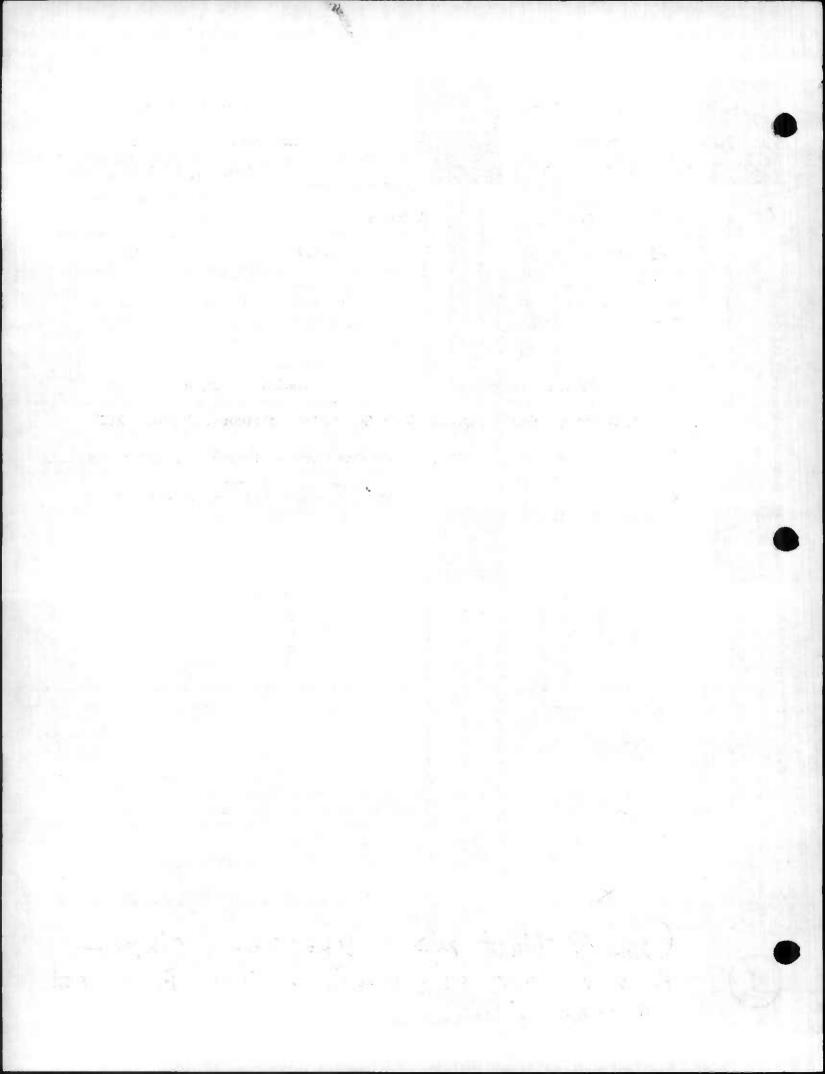
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sician		I. Decedent's Neme (First, Middle, La	ist)		1111			2. Dete of Deat Month			3. Time of Deeth
edical	L	John	ANTI	POROW]	CH			October	8°, 19	9 <sup>Veer</sup>	3:30 P.M
mlner	4	a. Facility Neme (If not institution, given	e street and number	er)			4b. City, Town, or	Location of Death	4c. County	of Deeth	
		Franklin Squar	ce Hospit	al Cei	nter		Roseda1			timore	
l r			Sex 7.	Aga (In yrs.	lest birthday) Yrs.	If Under 1 \ Months   D	faar If Under 24 Hrs eys Hours Min.		Year) 1924	9. Birthplec Country Maryl	e (Stete or Foreign and
by Funeral Director		Oa. Stata 10b. County		10c. Cit	ty, Town or Lo	cation			-	10d.	Inside City Limits
ţċ		Maryland Bali	timore				Middle Riv	er			1 ☐ Yes 2√ No
Funeral Director	1	Oe. Street and Number 3510 GLenwood Ro	vad			10f. Zip Co	de 1220	10	og. Citizen of United	Whet Country	
þ		1. Marital Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decede Armed Force 1 ☑ Yas 2 [ If Yes, Give Yeer or Dala	□No	1	Ves Deceden I Yes, specify	t of Hispanic Origin? (S Cuben, Maxican, Puer No Specify:	pecify Yas or No- o Rican, etc.)		ca - American ck, White, etc	
ted		15. Decedent's E (Specify only highest gre	ducation		16e. Deced	lent's Usuel C	ccupetion	ek in a	6b. Kind of B	usiness/Indus	try
Completed	-	Elementery/Secondery (0-12)	College (1-4c	or 5+)		tricio	one duning most of wo. etired) UN.	rking	Consa	tructio	n
BeC		7. Fether's Nema (First, Middle, Last	)				18. Mother's Na	me (First, Middle, N			
ToB		Dimitry Antipo	rowich				Bertha	C. Karoj	ochinsk	zy	
	-	19e. Informent's Name/Relationship (	Type, Print) (1)	life	19b. Mellin	g Address (S	treet end Number or Ri	rel Route Number,	City or Town,	Stete, Zip Co	de)
		Mrs. Theresa W.			3510	Glenwa	od Road B	altimore	Manuel	and o	1220
1		0e. Method of Disposition		20b. F	Plece of Dispos	sition (Name :	27	Deta	Oc. Location -	City or Town	, Stete
		1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special		to Hol	y Trin	ity Rus	sian Orthx	. 10/11/	1997 1	Dorseu.	MD
ouce.	2	21. Signeture of Juneral Service Lice	1see	0	22	Name and A	ddress of Fecility ICR Funeral	Home of	Dundal	ck. Inc	
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Physician/	-										
ıysi	P	art II. Other significant conditions of	ontributing to death	but not resi	ulting In the un	iderlying caus	e given in Pert i.				e cause of death?
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Be	2	5. Was case referred to medical exeminer?					26. Plece of Dec	ath (Check only one	)		
2		1 Yes 2 No	Hospitel: 1 Inpa	itient 2	ER/Outpatient	3□ DOA	Other: 4 Nursing H	lome 5 Reside	nce 6 Oth	er (Specify)	
	2	27. Menner of Deeth  1. Shaturel 5 Pending (Month, Dey Year)  28c. Injury at Work?  Work?					Injury at Work? 1  Yes 2  No	28d. Describe ho	w Injury occur	red	
Certification:		3 Sulcide 6 Could not b 4 Homicide determined	289. Place of	Injury - At ho etc. (Specify		et, fectory, of	fice	28f. Location (Str City or Town		er or Rural Ro	oute Number,
edical	2	29e. Certifier (Check only one) 1 Certifying Ph	ysicien: To the besinner: On the basis end menner	of examine	wiedge, death tion and/or inv	occurred et ti estigetion, In	ne time, dete and plece my opinion, deeth occu	, end due to the ca rred at the time, da	use(s) end ma ta end plece,	anner as state and dua to the	d. e ceuse(s)
Z.	2	9b. Signature end title of cartifiar				29c. Li	cense number	29	d. Dete signe	d (Month, Day	, Year)
		trouble	Q	cw	Le		036663		Octobe	r 9, 19	997
	3	0. Name end eddress of person who					D	144	Managara T		11227
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ate	ľ	OCT 44	02,000	strer's Signe							



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Deeth 3. Tima of Death 1997 **Physician** October HARRY BUZBY ORRICK 4:00 P.M. /Medical 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 6205 Mossway N/A Baltimore If Under 24 Hrs. 6. Data of Birth (Month, Pay, Year, Dec. 13, 1 5. Social Security Number if Under 1 Yaar 6. Sex 7. Aga (In yrs. last birthdey) 9. Birthplaca (Stata or Foreign Country) **Funeral** 1₩ 2□ F Months Deys 217-16-1972 1915 81 Director New Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits r than "natural", or items 23a or 28a-f short the Wodcal Examiner must be nothed at ty Yes 2 □ No Funeral Director Maryland N/A Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21212 U.S.A. 6205 Mossway Wes Decedent of Hispanic Origin? (Specify Yas or Noti Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 12. Was Decedent Ever In U,S. Armed Forcas? 14. Race - Amarican Indian, pernit. Pages 1 and 2 should be filed within 72 hours efter to Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Nes any finury or other traumatic avent, the Modical Energies any finury or other traumatic avent, the Modical Energies. Bleck, White, etc. 1 分 Yas 2 □ No If Aes, Give Yeer or Detas: WW II 1 Never Merried 2 Merried Specify: White 21215-0020 1 ☐ Yas 2 No Specify: Be Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 5+ years Food Broker Food Baltimore, Maryland 17. Fethar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Samue1 Stockton Buzby Louisa Wright Orrick 2 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mary Scott Buzby Weber (daughter) 7205 Lanark Rd. Baltimore, Maryland 21212 20b. Plece of Disposition (Name of cematary, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 10-9-97 Baltimore, Maryland Green Mount Crematory 22. Name and Address of Facility
Mitchell-Wiedefeld Home 21. Signeture of Funerel Service Licensee 6500 York Road Baltimore, Maryland 21212 Leva e raise 23a. Part1. Enter the disease, or shock, or heert failure. List complications thet caused the deeth. Do not enter the mode of dying, such as cardlec or raspiratory arrest, only one ceusa on each line. **Physician** /Medical Immediata Cause (Final disease or condition resulting In deeth) Examiner estrue The law requires that the death certificate be executed **bunal-transit** Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Diseesa or Injury that initieted events resulting in death) Last Pul Due to (or es e consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of): for use as the igned by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown of Vital Records. ð 24b. Wara autopsy findings available prior to completion of causa of death? page 2 should Be Completed 24a. Wes an autopsy this certificate has 1□Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: director. 25. Wes casa ratarred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 0 10 Hospitel: 1 Inpatient 2 ER/Outpatlent 3 DOA Othar: 4 Nursing Homa 5 Aesidence 6 Othar (Specify) 2 filled in by the funeral 27. Menner of Deet 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Tima of 26c. Injury at Work? Division After 5 Pending Investigation Natural s after death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 Sulcida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At homa, farm, straet, fectory, office building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral Completely filled Hospital Medical Certifying Physictan: To the best of my knowledge, deeth occurred et the tima, deta and place, and due to tha causa(s) end manner as stated.

| Continue of the basis of exeminetion end/or invastigetion, in my opinion, deeth occurred et the time, dete and piece, and dua to the cause(s) end menner stated. 29e, Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) JER 560 DC Registrer's Signeture 31. Date filed (Month, Dev. Yeer) State Registrar



State of Maryland / Department of Health and Mental Hygiene

Physiclan /Medical Examiner

Director

Funeral

by

Completed

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11:40 AM.

**Funeral** 

Director show

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Maryland 21215-0020

Baltimore.

**Physician** /Medical

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Exami buriel-tran Box 68760 physician pe Physician/Medical the 28 3 Records, by Completed peen Division of Vital or Attending Physician: Be Certification: To After deeth. ofter deeth Director:

P.O.

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Certificate of Death 1 Decedent's Name (First Middle Last) 2. Data of Daath Day 1997 Month ISABELLA P. BURROUGHS 05, OCT. 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Days 1□M 29 F 213-20-5662 Yrs 71 APRIL 7,1926 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD CITY BALTIMORE CITY Yas 2 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 2906 HUNTINGDON AVENUE 21211 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, atc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) MANAGER 12 FOOD 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumema) MERIDITH EARL HEDRICK GRACE ISABELLA 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MIKE REYNOLDS/SON 20 CENTER TRAIL FAIRFIELD, PA 17320 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) OAK LAWN CEMETERY BALTIMORE, MARYLAND OCT 9,97 21. Signature of Funeral Sarvica Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 23a. Part1. Enturing disease, or complications that ceusad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or ream failure. List only one cause on each line. 21224 Defoximate Interval Between Onset and Death Immediate Cause (Final disaese or condition resulting in death) Ikad Organies Due to for as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 45 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy · upal 12 Yes 2 No 1 Yes 26. Place of Death (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was cese referred to medicel examiner? 1X Yes 2□ No

1 ☐ Naturei

3 Suicide

29a. Certifiar (Check only one)

4 ☐ Homicide

27. Menner of Death 5 Pending 2 Accident

investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Year) 10-5-97

28b. Time of Injury ankouson

28c. Injury et Work?

1 ☐ Yes 2 HNo

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28d. Describe how injury occurred subject felldown stairs

Location (Street end Number or Rural Route Number, City or Town, Stete) 2906 Huntin, Form St 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to tha cause(s) and manner stated.

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Yeer) OCT. 06, 1997

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

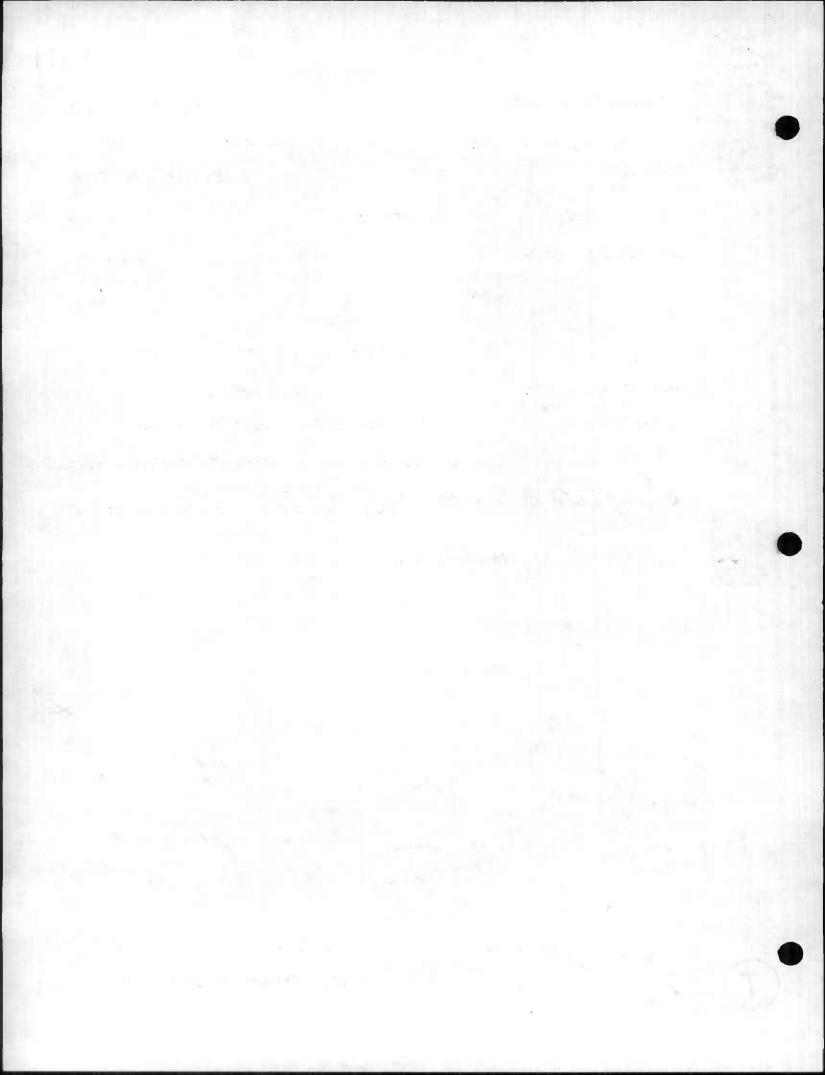
Dennis J. (hute 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Dey, Year)

32. Registrar's Signeture

who Murdson Randall

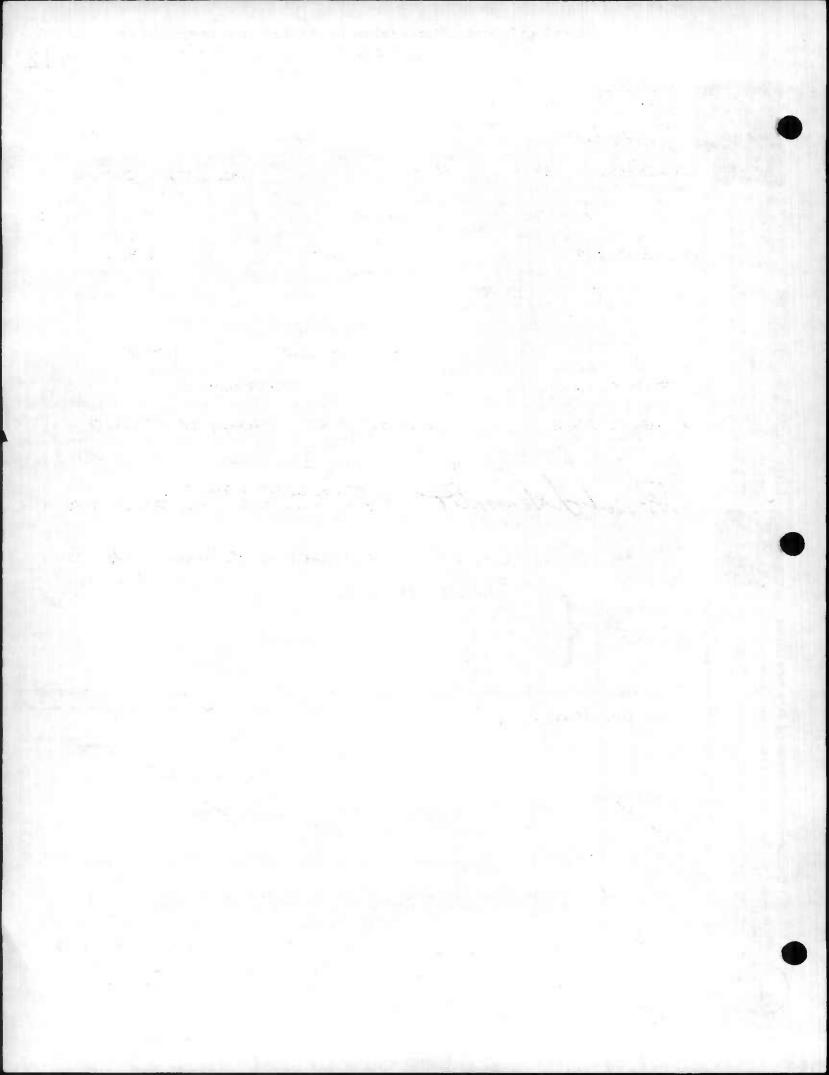
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State of Maryland / Department of Health and Mental Hygiene 97 30712

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uth with the Mar 23a or 28a-1 s unt be notified	1	0e. Street and Number 128-2B KINSHIE					10f. Zip Coo	e 222	2			10g. Citizen	of What Could	*
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To the Hospital or Attending P within 24 hours eiter death.  To the Funeral Director: After completely filled in by the funer.  Medical Certification:	1	3   Sulcide 4   Hornicide  6   Coulded determine to the county of the co	d not be mined ring Phys	building lclan: To the bear: On the bas and manne	est of my known is of exemination of stated.	) viedge, death	occurred at the vestigation, in m	e time, ny opin ense n	nion, deet	d place, h occurr	City or Ton and due to the ed at the time,	cause(s) enc date and pla 29d. Date si	ce, and due t gned (Month,	othe cause(s)  Day, Year)
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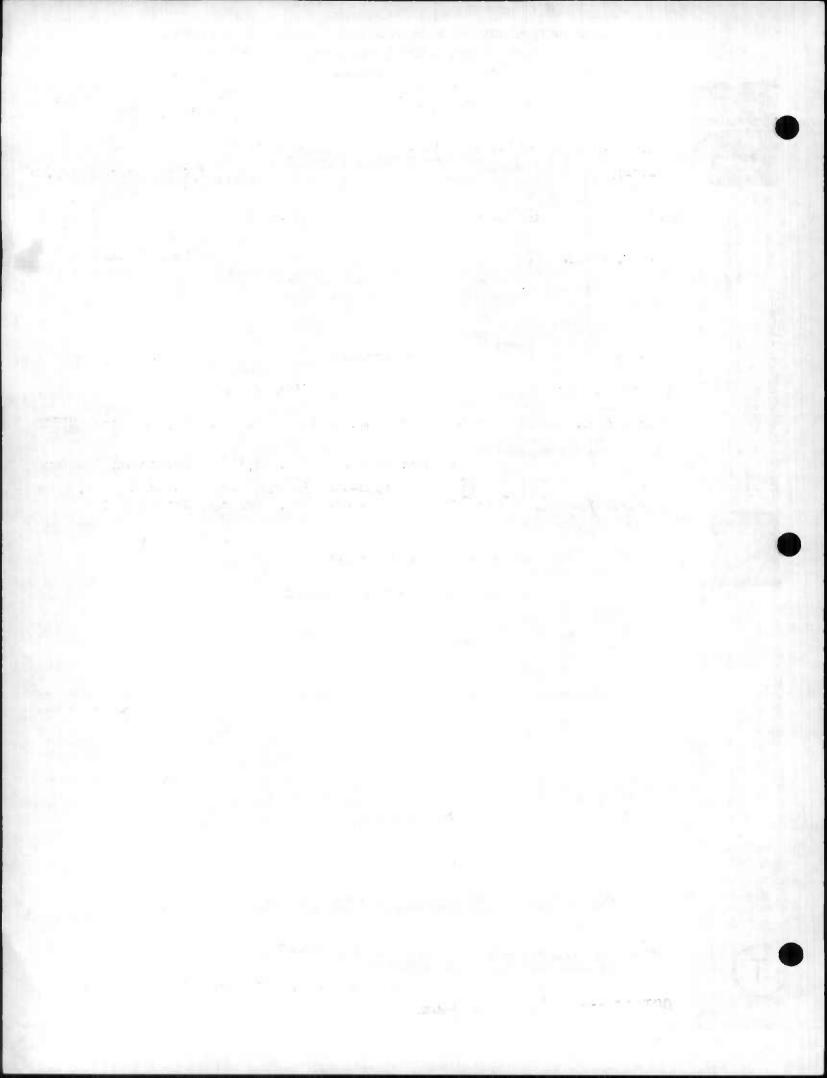
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State of Maryland / Department of Health and Mental Hygiene

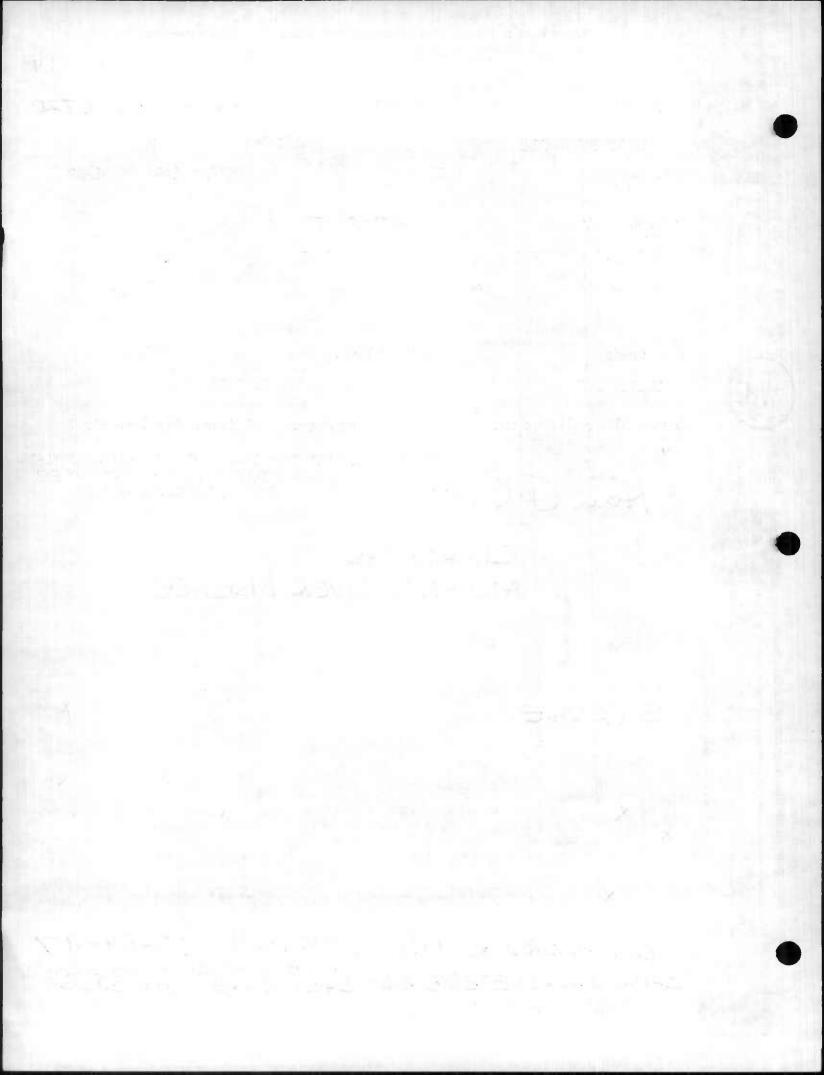
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State of Maryland / Department of Health and Mental Hygiene 9.7

					Ce	rtificate	of Dear	th		Reg. No.	,	00114
Dharalas		1. Decedent's Name (First, Midd	fle, Last)						2. Date of D	eath	Vans	3. Time of Death
Physici /Medi		DOROTHY			BLAC	KWELL			OCT.	O8	1997	0720
Examir		4a. Facility Name (If not institution	on, give street and	number)			4b. City,	Town, or L	ocation of Dea		ty of Death	
		3810 BOWERS	AVENUE				BAL	TIMOR	RE	N.	/A	
Funerai		5. Social Security Number	6. Sex		s. last birthday	If Under 1 Y	ear if Und	der 24 Hrs.	8. Date of B	irth	9. Births	place (State or Foreign
Director		217-38-4720	1 L M 2 LA		57 Yrs.	Wild and		Nint.	SEPT.	8 1940	MAR	YLAND
2 .		Usual Residence of Decedent 10a. State 10b. Count		100 (	City, Town or L	a a a tion						
sho sho	5		,	100.0							Ι,	0d. Inside City Limits  XX Yes 2 □ No
N THE	Director	MARYLAND N/A			BA	LTIMORE						777
6 6 8		10e. Street and Number				10f. Zip Co				10g. Citizen of		itry?
esth with the Marylan na 23s or 28s f show must be notified at	Funeral	3810 BOWERS			11.0		21207	0	* **	U.S.		
ar dos hems her.m	Š	11. Marital Status	Armed	ecedent Ever In Forces?	0,8. 13.	Was Decedent If Yes, specify	of Hispanic Cuban, Mexi	can, Puerto	pecify Yes or No Rican, etc.)	0- 14. He Bi	ce - Americ ack, White,	
120	by F	1 Never Married 2)(1)(Ma 3 □ Widowed 4 □ Divorce	If Yes,	es XD No Give or Dates:		1 □ Yes 2 🖔	No Spec	ify:		Speci	y: BLAC	CK
215-0020 thin 72 hours at en "natural", or Medical Exam			nt's Educetion	Dates.	16a Dece	dent's Usuai O	coupation			16b. Kind of I	Buelnose/In	dustry
15	Completed	(Specify only highe	est grade complete		(Give	dent's Usuai O kind of work d DO NOT use re	one during m etired)	nost of worl	king	TOD. KING OF	3001110037111	adotty
with the liber	mo	12th grade	Colleg	e (1-4or 5+)		GE TECH				HOSPI'	TAL	
6	Be C	17. Father's Name (First, Middle	Last)					other's Nam	ne (First, Middl	e, Maiden Surna		
LEEDAP.	To B	WALTER CAIN					I	MAE B.	. CAIN			
S ASSESSED	-	19a. Informant's Name/Relation	shlp (Type, Print)		19b. Mall	ing Address (St	reet end Nur	m <i>ber</i> or Ru	ral Route Num	ber, City or Town	n, State, Zip	Code)
200		Roscoe Blackwe	11/Hushai	nd	3810	Rowers	Aveni	IO R	altimor	e, Mary	land :	21207
O - Hug		20a. Method of Disposition	11/114354		Place of Diso	osition (Name of matory or other	of .	IC, DO	Date	20c. Location		
mo anti-m		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		om State		FOREST		PANS	10-14	OWINGS	MTLL	S, MARYLANI
Baltimor semit. Pages Separtment of important: if is inty injury or o		21. Signature of Funeral Service		ur								UNITY F/H
B Per Per Per Per Per Per Per Per Per Per		b 610 .	(21)	O.T.	10					ORTH AV		3,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		23a Part   Enter the disease of	r complications the	et caucad the de	oth Donot on	tor the mode of	duina auch					Annualmeta
Physician	1	23a. Part1. Enter the disease, o shock, or heart failure. Lis	only one cause o	n each ilne.	atti. Do not on	ter the mode of	dynig, such	as coldiac	or respiratory	antoot,		Approximate Interval Between Onset and Death
Physician / /Medical		Immediate Cause (Final		100	110	<10						
Examiner		disease or condition resulting in deeth)	a	LIRA	LTU	76						
	e		Λ	Due to	or es e conse	quence of):	150	, )	ICE.	4SE	1	
d ansit	Examiner	Comments the first one of the	b	i Kor	(or as a conse	J	VGV	- 4	120	476	1	
D, exec in an	Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying		Due to	(Or as a conse	quence or).					1	
Box 68760, eath certificate be executed ettending physician and I for use as the buriel-transit	edicai	that initiated events	C	Due to	or as a conse	nuence of):					-	
68 g phy es th	Pa	resulting in death) Last		200101	(01 43 4 0011301	querios 01).					1	
OX ondin use	M/u		d									
. 70 60	Physician	Part II. Other significant conditi	one contributing to	death but not re	sulting in the I	inderlying caus	e given in Pa	ort I	23b Did	I tobacco una c	ontribute to	the cause of death?
o, the	hys	0 - 0		J GOGILL DOLLING	outing without	moonymg ozdo	o givon arr o			Yes 2□ No	3 Pro	A.
	by P	SIRC	KE							, 100 20110		, ,,
ords requires men sign hould be									24a. Wa	s an autopsy		ere autopsy findings
0 > 00	olet								per	formed?	co	allable prior to mpletion of ceuse death?
The lay	Completed								10	Yes 2 No		
Vital Reviction: The law		25. Wes case referred to medica					00.00	4.0			1 [	Yes 2 No
	o Be	examiner?	Hospital:	Dispetions Of	T CD/Out-atio	-1 2 DOA	Other		th (Check only		h (O)	La
Phys r this aral dii	-	27. Manner of Death	28a. Da	te of Injury	28b. Time of		injury at	Nursing He		how injury occu		y)
Vision o Attending Ph or death. ector: After th by the funeral	tior	1 Naturel 5 Pendi 2 Accident invest		lonth, Day Yeer)	Injury	М	Work? 1 ☐ Yes 2	□No				
Division or Attending after death. Director: A lin by the fi	fica	3 ☐ Suicide 6 ☐ Could	not be	ace of Injury - At	home, farm, st	reet, factory, of			28f. Location	(Street and Num	ber or Rura	al Route Number,
Division  or Attending after death. Director: After d in by the fune	Certification:	4 Homicide		ilding, etc. (Spec						iwn, State)		
Division  To the Hospital or Attandition 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 12 Certifyi	ng Physician: To	the best of my kn	nowiedne deat	h occurred at th	ne time date	and place	and due to the	cause(s) and n	anner as s	tated
Hoy Hoy Pur Pur Pur Peterly	edical	(Check only 2 Medical one)	Examiner: On the	e basis of examinance stated.	ation and/or Ir	vestigation, in r	ny opinion, o	death occur	rred at the time	, date and place	, and due to	the cause(s)
To the vithin To the comple	Me	29b. Signature and title of certific		/		29c. Lie	cense numbe	er		29d. Date sign	ed (Month,	Day, Year)
- S - 0		1/18	o lou	. 0.	MI	7	25	45	-9	10-	-09	-97
		30. Name and address of person	who of modeland	augo of doots fire	m 220\ C.	Deint\	1 1/54	400	001	1111	100	00000
9		CHIA)(1)1072	C DA	ause of death (Ite	1E 11	X . F	100	160	KUL	LINGT	4120	- KONO
Sta	to	31. Date filed (Month, Day, Year	32	. Registra's Sign	fature /V	2 6	470	17V	1110	) ///	7. 5	1228
Registr		UCI	0 1997	> Julia	Davidson	- Aandell						

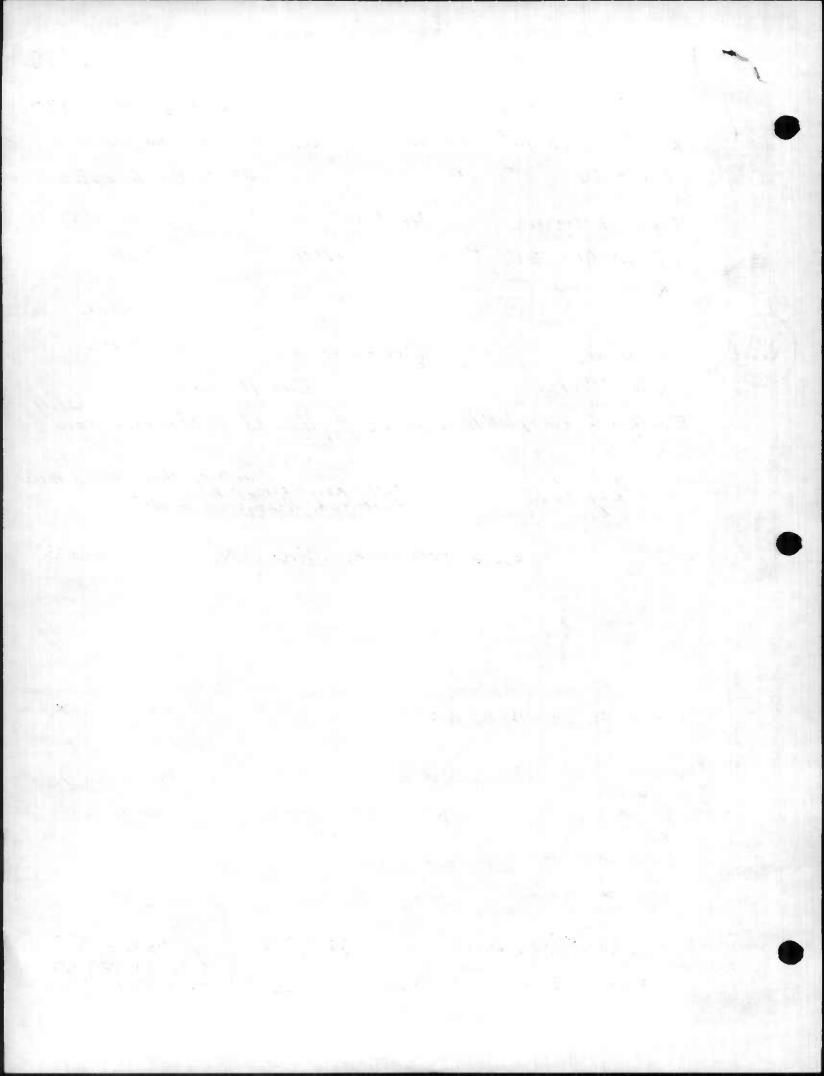


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month BESSIE 300 6:50 PM. /Medicai 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner H Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) DORTHWEST Yospital CEnter Birthplece (Steta or Foreign Country) 6. Sex 5. Sociel Security Number 7. Age (In yrs. lest birthday) 1 M 2 F 238 - 82 - 0238 Usuel Residence of Decedent Yrs Director JAN. 3, 1916 L. CArolina 10a State 10b County 10c. City, Town or Location 10d. inside City Limits Honkton 1 Tes 2 No BALHMOR Director Horstons r 28a-t 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8 must be USA 21111 238 BIG Falls 17323 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 2 No
If Yes, Give
Yeer or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) Race - American indien, Bleck, Whita, atc. 1 Never Married 2 Married ò 1 ☐ Yes 2 ☐ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Black 16e. Decedent's Usuel Occupation (Give kind of work done during most of working , life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry OWN HOME Elementary/Secondary (0-12) College (1-4or 5+) 17. Fathar's Name (First, Middle, Last) IOME MAKER 18. Mother's Nema (First, Middle, Meiden Sumeme) Be Booth HENDRICK WILLIE LDA 0 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2//// important of Health as any injury or 20b. Place of Disposition (Name of cametery, cremetory or other place) EUELEIN AMPDE11 Markfor Marylans Baltimore, 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 Buriei 2 ☐ Cremetion 3 ☐ Removei from State SPRING HOPE, N.C BETHEL AME Church Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility CHATMAN - Homs Feneral Home 5240 Keistel How Loss 21. Signature of Funeral Service Licenses BOH; HOTE, MANY CARD SIGHT PROPERTY OF THE PRO Approximate Intervel Between Onset end Death **Physician** /Medicai Immediete Cause (Final MYDCARDIAL INFARCTION 6 HOURS a ACUTE diseese or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated avents resulting in death) Lest pue Due to (or es e consequence of): P.O. Box 68760, ding physician ise es the buria Physician/Medical Due to (or es a consequence of) for u signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown CEREBRAL VASCULAR Records, 24b. Were eutopsy findings evelleble prior to Completed 24a. Was en eutopsy performed? complation of cause of death? 1 Yes 2000 1□ Yes 20 No certificate Division of Vital 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28e. Dete of Injury (Month, Dey Yeer) 27. Menner of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred edical Certification: After 5 Pending Investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun. Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, Steta) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

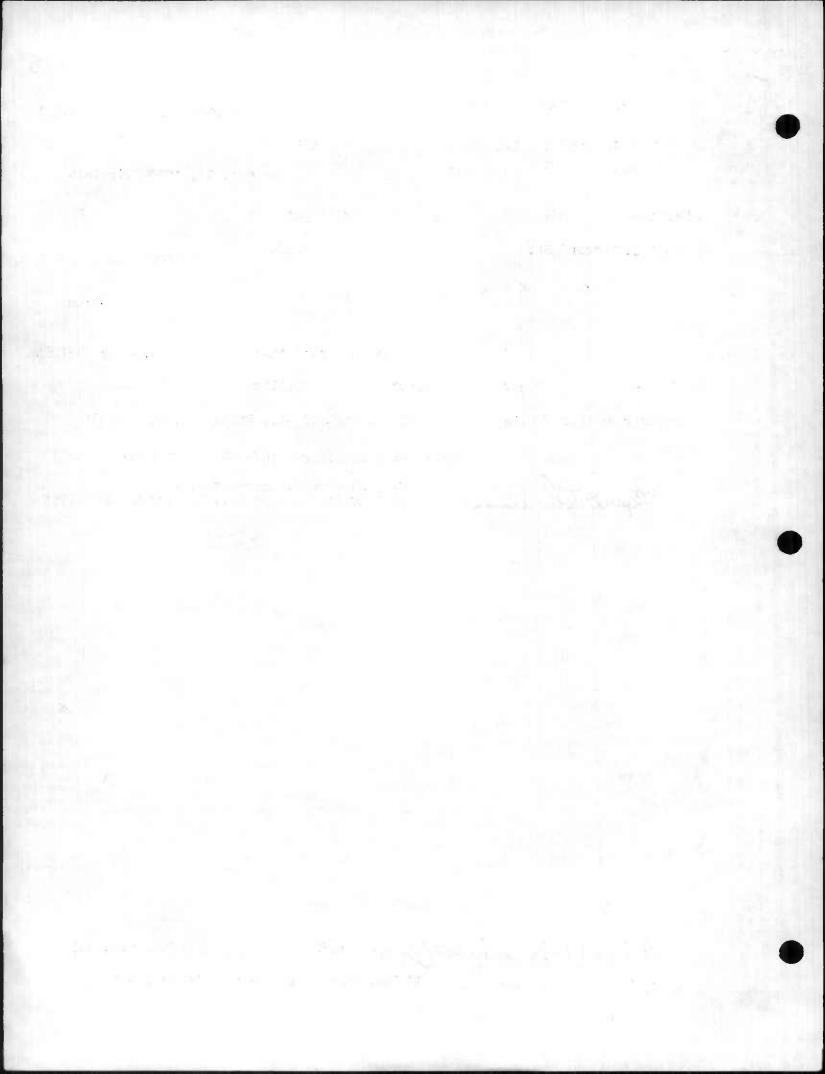
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the ceuse(s) end mannar stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 5401 040 COURT RVAD 30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print) CLIFFORD S. FABER m.O. NORTHWEST HOSPITAL CENTER 32. Registrer's Signature 31. Date filed (Month, Dey, Year) State Registrar



State of Maryland / Department of Health and Mental Hygiene

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~	J.	U	U	-	1	

	an	Stephen Ke	ent Ba	ker					Month	Day	Yaar	3. Time of Death
/Medical Examiner		4a. Facility Name (If not institution, g						4b. City, Town, or I	OCTOBE			06:20 AM
										4c. County	n/a	
Funeral		2031 EAST LOMBARD STREET  5. Social Sacurity Numbar  6. Sex  7. Age (In y			BAITIMOR  last birthday) If Under 1 Year If Under 24 Hrs.				Birth 9. Birthplace (State or Fo		lace (State or Foreign	
Director		224 82 2401	40 Yrs. Months Days Hours Min.			Oct. 29	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Oct. 29, 1956 Virginia					
Mo to		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City L										0d. Inside City Limits
r 28a-f ahow notified at	ector	Maryland n/a Baltimore						imore		1 Yas 2 □ No		
23a or 2	Funeral Director	2031 E. Lombard St.			10f. Zip Code 21231					10g. Citizen of What Country? United States		
or items	by	11. Marital Status  1 ☐ Never Married 2 【XMarried 3 ☐ Widowad 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates:		S. 13. Was Dacedent of Hispanic Origin' If Yas, specify Cuban, Mexican, P				pecify Yes or No o Rican, etc.)		14. Race - American Indian, Black, White, etc.  Specify: White	
natural',	Completed	15. Decedent's (Specify only highast of	Education		16a. Decedent's Usual Occupation (Give kind of work done during most of work			kina	16b. Kind of B	6b. Kind of Business/Industry		
. S S	mple	Elementery/Secondery (0-12)	College (1-4or 5+)		(Give kind of work done during most of wor life. DO NOT use retired)							
- L	S	12			Physicians Assis		T-		Emergency Med		Medicine	
ad off	o Be	17. Father's Name (First, Middla, La: William			Baker Phylli			ne (First, Middle, Maiden Surname)  S Herbaugh			1	
end Mente is markad sumatic e	2	19a. Informant's Name/Relationship					/Streat	t end Number or Ru	_			
		Beverly Fischer				-		ard St.,			212	
Y or		20a. Method of Disposition  1 ☐ Burial 2 X Cramation 3  4 ☐ Donation 5 ☐ Other (Space)	Hemoval from Stata			matory or of	ther pla		Date /8/97	20c. Location Balti		
Usparmer Important: any injury once.		22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore							e. MT	21286		
	1	23a. Part1. Enter the disease, or co shock, or heart feilure. List on	mplications that caused	the death.							-	Approximete Interval Between
ysician /ledical aminer	her	Immediate Cause (Final disease or condition resulting in death)  NARCOTIC INTOXICATION  Due to (or as a consequence of):									Onsat and Deeth	
certificate be executed ding physician end use es the bunal-transit	Examiner	Sequentially list conditions, if any, leading to immediate	b	Due to (or	as a consec	quance of):						
	edical	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	c. — Dua to (or as a consequence of):									
ttendin or use	Physician/M	d										
ped f	/sic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did	tobacco usa co	ntributa to	the cause of death?	
detec	by Phy							10	1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknow			
	Completed b							24a. Wes	. Wes an autopsy performed?  24b. Were autopsy finding available prior to completion of ceuse of death?		ailable prior to	
ite hes page 2	E								1)20	Yes 2 No	1,5	Yes 2 No
	Be C	25. Was cese referred to medical						26. Place of Dea	ath (Check only	one)		
dire ce	2	examiner?  1X) Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nurs							lome 5 Resi	dence 6 Ott	er (Specif)	y)
fter th		27. Menner of Deeth 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da)	ry y Year) 2	28b. Time of Injury	f A 2	8c. Inju Wo			how injury occur		
ctor: A y the fu	cati	2 Accident investigati	10/0/3/10	10/6/97 found 6:10 found <sup>M</sup> 1□ Yes 2 (X)No				Yes 2 XNo		ngested d		
within 24 hours effect death.  To the Funeral Director: After this completely filled in by the funeral	Certification:	4 Homicide determine	ed 286. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Routa Number, City or Town, State)2031 E. Lombard Street, Baltimore, Md.				
within 24 hours end To the Funeral Dir completely filled in	edicai	29a. Certifiar (Check only one)  1 Certifying Phyalclan: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated.									ated. the cause(s)	
Toth	Me	29b. Signature and title of certifier 29c. Licansa number						sa number	29d. Data signad (Month, Da		Day, Year)	
		30. Name end address of person who completed cause of deeth (Item 234) (Type, Print)							OCTOBER 06, 1997			
		30 Name and address of access	o completed acres of t	noth /11	2265	Deins						

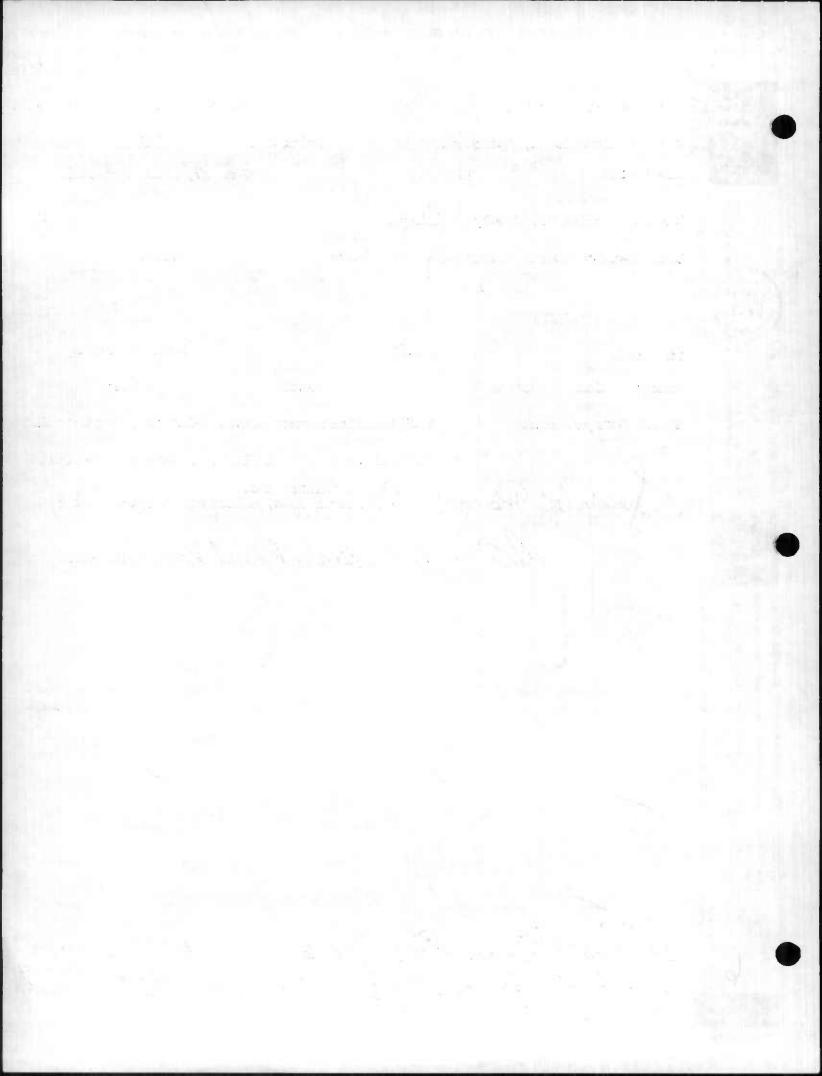


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an		e (First, Middla, i	Last)					2. Data of Deat			3. Tima of Death
	Mildre	d Ethel	Bogner					October		7 <sup>Yesr</sup>	8:50 A.M
cal ner			giva street and number,	)			4b. City, Town, or	Location of Death	4c. County		
	8523 Hea	throw Co	ourt, Apart	ment B	3		Baltimor	e	Balti	more	County
	5. Sociel Security N 213–18–1	283	Sax 7. Ag	ge (In yrs. las 75	st birthday) Yrs.	If Undar 1 Yaar Months Days			Year) 1922	9. Birthp Coun Mary	laca (Stata or Foreign official) Land
	Usual Rasidence o 10a. Stata	10b. County		10c. City,	Town or Loc	ation				1	0d. Insida City Limits
tor	Maryland	Baltin	ore County	Balt	timore						1 ☐ Yas 2 ☑ No
Director	10e. Street and Nu					10f. Zip Coda		1	0g. Citizen of V	Whet Coun	ntry?
0	8523 Hea	throw Co	ourt, Apart	ment B	3	21236			U.S.A.		
by Funeral	11. Marital Sfefus	ied 2 Married	12. Wes Decedant Armed Forcas	Ever in U,S.	. 13. W		Hispanic Origin? (5 pan, Maxican, Puer Specify:	Specity Yas or No- to Ricen, atc.)	14. Rac	e - Americ ck, Whita, v: Whi	atc.
Efted	(000	15. Decedant's	Education		16a. Deceda	ant's Usual Occu	pation		16b. Kind of Bu		
Comple	9th Grad	endery (0-12)	grada complated) Collega (1-4or	5+) C	lita. Di	O NOT use retire	during most of wo	irking	Laundr	y Con	mpany
Be	17. Fether's Name		_					me (First, Middla, M			
2	George	Buck	Deares				Katie			hler	
	19a. Informent's No							ural Routa Number			
	Lenore G		lughter						LTIMORE 20c. Location -		ryland 2123
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		5 Other (Special Lie		Oak		Cemetery Nama end Addre		/11/97 I	saltimo	re, M	Maryland
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	Auc	inita (	2 Prom	d tha death.	Jo. 64	hn C. Mi 15 Belai	iller, In	Baltimore	e, Mary	land	Approximata
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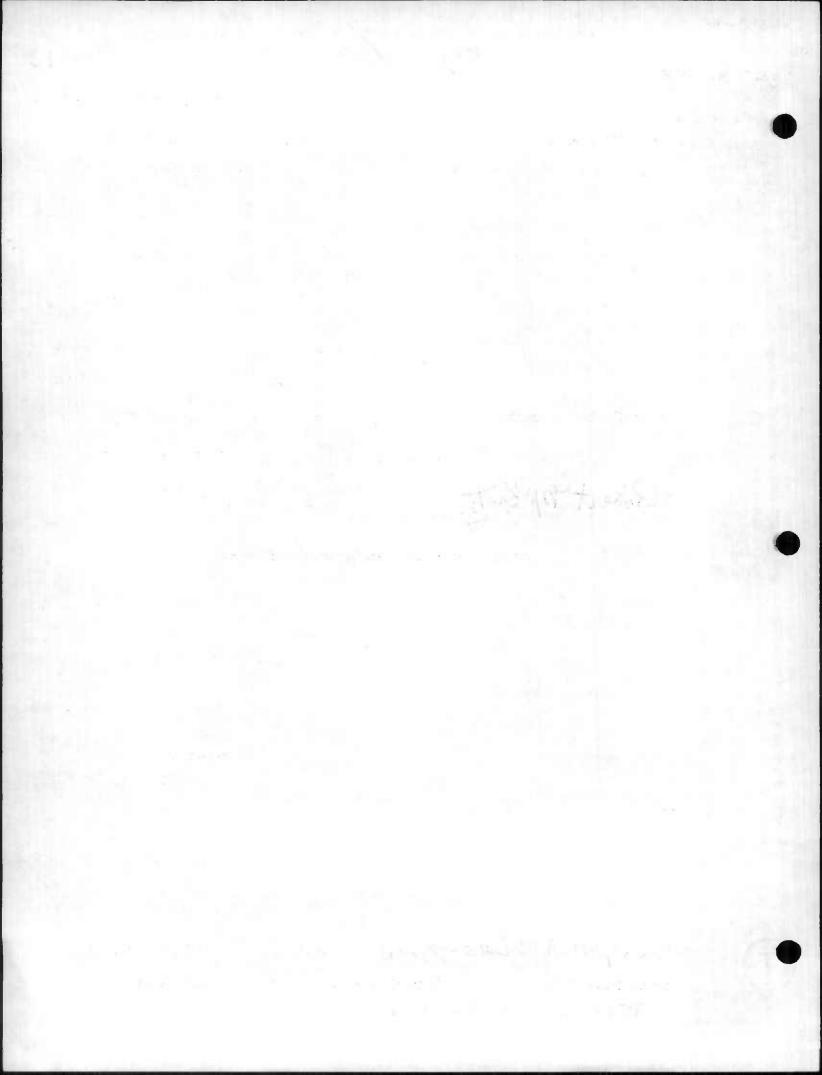
State Registrar



State of Maryland / Department of Health and Mental Hygiene

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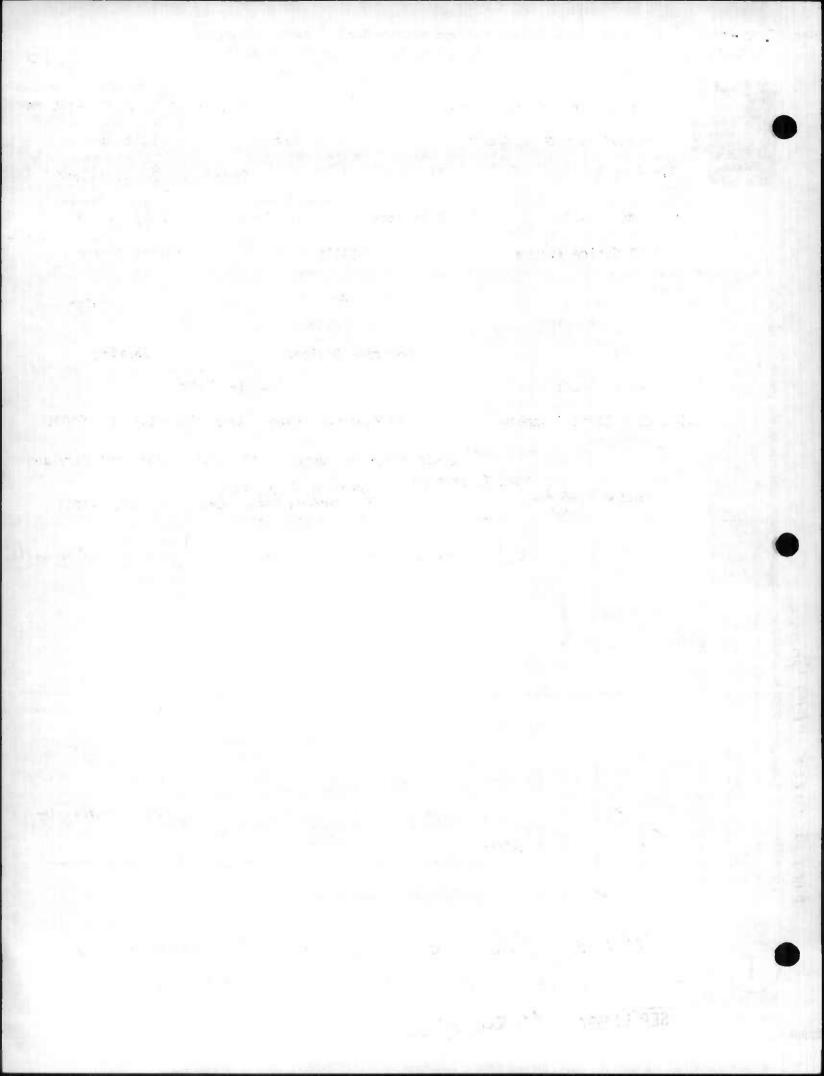


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

30719

Physician /Medical Examiner uneral	Ma 4a. Facility Nam	e (If not Institution, giv	phine C	izek				2. Date of De Month	Day	Year	3. Time of Death
uneral								October	8	1997	1:55 pm
	dil	chwict Hoc				4		Location of Deet			
	5. Social Securit	christ Hos		ge (in yrs. lest :	hirthdeyl If Un	der 1 Year	Towsol If Under 24 Hrs	_		timor	
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	10a. State	10b. County		10c. City, To	own or Location					10	d. Inside City Limits
cto	Marylan	d N/A		Bal	timore						1 Nes 2 No
al Director	10e. Street end				10f.	Zip Code			10g. Citizen of V		-
60	6002	Eunice Av	enue	5.7		21214			United	1 Stat	tes
by Funeral	1	s arried 2 Married d 4 Divorcad	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Yeer or Dates:			cedent of Hi pecify Cuber 2 XI No		Specify Yes or No to Rican, etc.)	Specify	e - America k, White, e	
	0011100116	15. Decedent's Ed		16	Sa. Decedent's U	sual Occupa	tion		16b. Kind of Bi		
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E		12	College (1-40)	34)	Mortgag	ge Off	icer		Ba	inking	J
Be	17. Fether's Ner	ne (First, Middle, Last)						me (First, Middle	Meiden Surnem	ie)	
To Be C	Fra	nk Cizek						onia Ko			
		Name/Relationship		1				urei Route Numb			
		c Cizek /	мер <b>пе</b>	OOL DI			d Lane		Connecti		06001
OUCe.	20a. Method of I	2 Cremetion 3	Removal from State	ceme	of Disposition (/	r other pleci		Dete	20c. Location -		
		n 5 Other (Specifi			d Ridge			10/13/97	Balt	imore	,Maryland
SUCE.	21. Signature of	Funeral Servica Licar	Mark T.	Zavoyr	la Leo	end Addres	s of Fecility J. Ruck,	Inc.			
2006	- MA	me 1. Ser			530	5 Har	ford Roa	d Balt	timore,	Md.	21214
	23a. Part1. Ente	er the disease, or compeant failure. List only	plications that cause one cause on each li	d the deeth. Dine.	o not enter the m	ode of dying	j, such es cardia	c or respiretory a	rrest,		Approximete Interval Between Onset and Death
an :al	Immediate Caus	e (Final	01.	1.			.1			1	
er	disease or cond resulting in deal	ition	a. Cho	( Brid	TOCA	rein	oma				3 mon
<b>P</b>					a consequence					1	
Examiner	Sequentially list	conditions	b	Due to (or es	a consequence o	M).				<u> </u>	
EX	Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated eve	o immediate		200 10 (0. 00		.,.					
n/Medical Examir	thet initiated ever resulting in deat	or Injury	C	Due to (or as	a consequenca o	if):				-	
n/Med	Tooding in ood	L								1	
			d								
Physicia	Pert II. Other sig	nificant conditiona c	ontributing to death b	ut not resulting	in the underlyin	g ceuse give	n in Part 1.	23b. Dld	tobacco use co	ntribute to	the cause of death
Phy								1 🗆	Yes 20 No	3 Prob	ably 4 Unknow
l by										Cab 14/-	
Completed by Physicia								24e. Wes	en eutopsy med?	eva	re autopsy findings liable prior to apletion of cause
d E											eath?
								10	Yes 2 No	1 🗆	Yes 2 No
Be	exeminer?	ferred to medical	Hospitel:			DOA Othe	AF.	ath (Check only	A		11
	1 Yes 2		28a. Date of Inju	iry 28t	Outpetient 3	ססת	4 Li Muising 1	dome 5 ☐ Resi 28d. Describe	dence 6/20pth how injury occur	er <i>(Specify,</i> red	Hosper
cation	1 Naturel	5 Pending	(Month, De	y Year)	Injury M	28c. Injury Work	? ′es 2 □ No		, , ,		
Certification:	3 Suicide	6 ☐ Could not be	28e. Placa of Inj	jury - At home,	farm, street, fact				Street end Numb	er or Rural	Route Number,
ert	4 Homicio	е	building, et	c. (Specify)				City or To	wn, Stete)		
Medical Certifi	29a. Certifier	1 Certifying Ph	ysician: To the best	of my knowled	ge, death occurr	ed et the tim	e, date and place	a, and due to the	cause(s) and ma	nner as sta	ited.
edical	(Check only one)	2 Medical Exam	iner: On the basis o and manner st	f exemination a eted.	and/or investigati	on, in my op	inion, deeth occi	urred et the time,	date end place,	and due to	the cause(s)
Σ	29b. Signature e	nd title of cartifier	10			29c. License			29d. Date signe		
	1	Andhony	Kly	mo		Das	205		October	8,19	97
	- //		nomploted saves of a	leath (Item 23s	(Type, Print)					-	
	30. Name and a	dress of person who		- Court (Month Ede	41 - 4						
	30. Name and a	Riley G		701 1	e) (Type, Print)  V. Chev	les St	Boli	6. Md	2120,	k	
completely filled in by the first at the fir	W.A.		-Bme 6	ar's Signeture		les St	Boli	to, ma	2120,	k	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30720 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Dey RUTH LIAMPAGLIO OCTO OSR 8 1997

ocation of Deeth 4c. County of Deeth MAZL D.A05:16 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** If Under 1 Year If Under 24 Hrs.

Dews Hours Min. FAUSTON GENERAL HOSPITAL HARFORD 9. Birthpiece (State or Foreign Country)

MARYLAND 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 1□M 28 F Months Yrs. Director 8P18 01 E18 JU17361930 Usuel Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ris 23a or 28a-f st 1 ☐ Yes 28 No Director MARVLAD HARFORD BEL AIR 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 705 30 Y2000W I'wer U.S.A Funeral 21014 Pages 1 and 2 should be filed within 72 hours efter death nent of Health and Mental Hygiene.
int: If Item 27 is merked other than "natural", or items 23 11. Maritei Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 þ 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced "natural", Completed 7 is marked other than "nature treumatic event, the Mousain 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry POINT BRILL Elementery/Secondery (0-12) College (1-4or 5+) 12 YRS. CREDIT Union 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) REHAK Divod BERDA ZILITTO 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) PAUL R. LIAMPAULIO BLATR MARYLAND

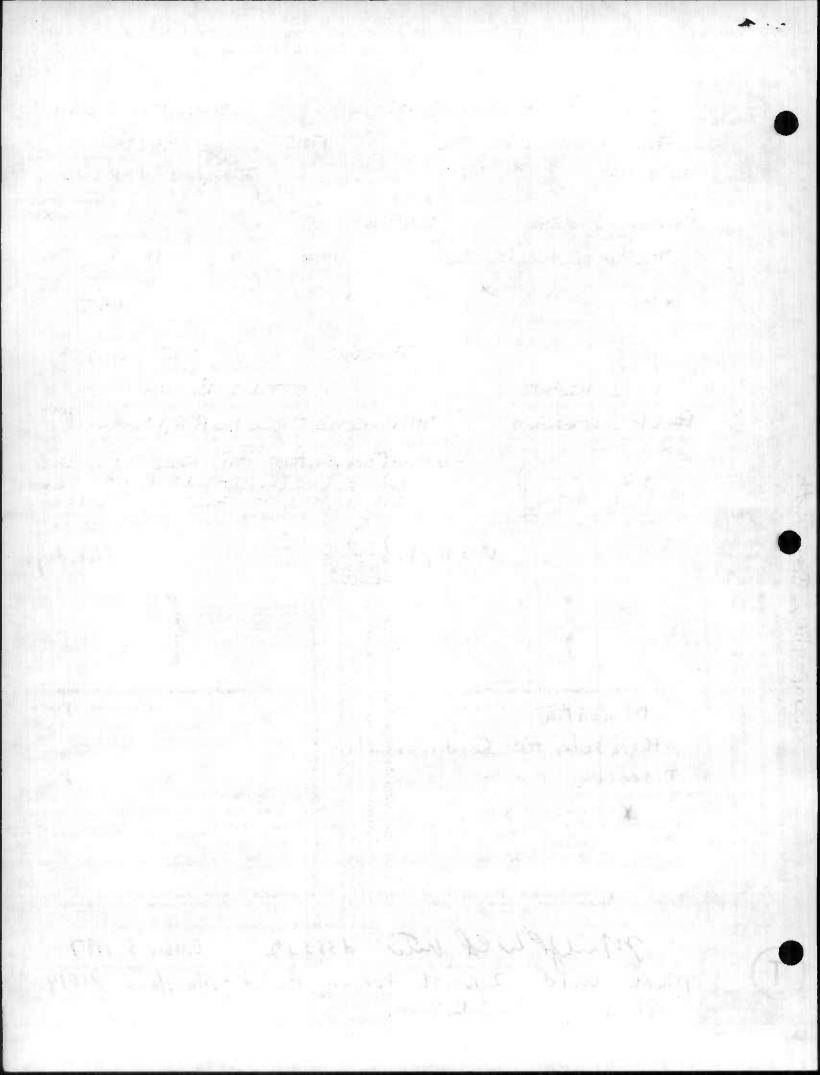
Dete | 20c. Location - City or Town, Stete 711 WOODSY OF PIRELS 20b. Pieca of Disposition (Neme of cemetery, crematory or other piece) 20e. Method of Disposition Dete 6 1 Buriai 2 ☐ Cremetion 3 ☐ Removal from State OCT: 11, 4 ☐ Donetion 5 ☐ Other (Specify) HIGHVIEW | SMORIALTARK 1997 FALLSTON / JARYLAND 21. Signature of Funerei Seption Licensee 22. Name and Address of Facility HAPL - BILAIR, A.A. EVANS FUNERAL CHAPL - BILAIR, A.A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximete Intervel Between Onset and Deeth **Physician** five days. /Medical Immediete Ceuse (Finel Viosepsis disease or condition resulting in death) Examiner Due to (or es e consequence of): buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last pue Due to (or es a consequence of): Ciampaglio the Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ate has been signed by the page 2 should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia þ 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? Atheroscherotic Cardiovascular D. sease After this certificate 1 Yes 2 PNo Division of Vital director, 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitei: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No To the Hospital or Attending Physical Comments of the Function of the function 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Neturel 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end menner steted. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) d35522 October 8, 1997 30. Name and address of person wit Avenue Bel Air Masyland 21014. North Ylark 31. Date flied (Month, Day, Year) Registrar's Signature State who Davidson 1 0 1997

DHMH 16 Rev 6/95

Registrar

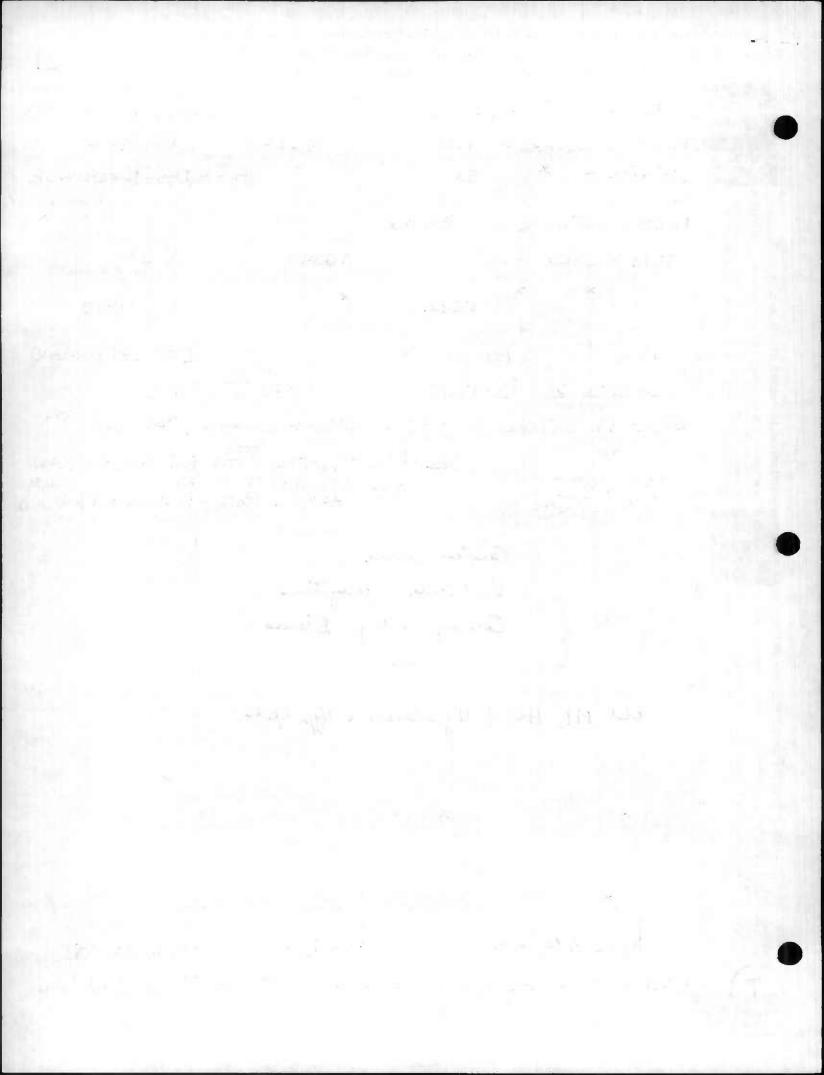
RITH



State of Maryland / Department of Health and Mental Hygiene

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					Certific	ate of	Death	R	eg. No.	1 0	012
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/Medica		HOWARD	E. LUR	nolss				928012O	- 1000	10 F	3:46 P.
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Funeral		5. Social Security Number 6	Sex 7. Ag	ge (In yrs. last	Mont	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey	Yeer)	9. Birthplece	(State or Fo
Director		230 42 8465 Usual Residence of Decedent	DAM ZUF	53	Yrs.			AUGAB	loth	BUNDA	LVANI
show		10e. Stete 10b. County		10c. City, To	own or Location					10d.	Inside City L
28a-f sho	Director	MARMAND BALTIC	ORE	CAR	KZUZY						1 Yes 25
or 26	e l	10e. Street end Number			10f.	Zip Code		1	0g. Citizen of \	Whet Country	?
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Home Degrad	Funeral	11. Maritel Stetus	12. Was Decedent Armed Forces?	Ever In U,S.	13. Was De	cedent of I-	lispenic Origin? (Spe en, Mexican, Puerto F	cify Yes or No- Rican, etc.)		e - Americen l	
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is m		19e. Informant's Neme/Reletionship	(Type, Print)	1	9b. Mailing Addr	ess (Street	and Number or Rura		City or Town,	State, Zip Co	21234
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5 = 5		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3	☐Removel from State	0000	of Disposition (internatory of	veme or or other ple	ce)	Dete	20c. Location -	City or Town,	State
		4 □ Donetion 5 □ Other (Spec		GRSS	NOON	SITE	MORY	1997	BALlin	ORS ME	ARYLAR
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After th funeral	=	27. Menner of Deeth  1 Neturel 5 □ Pending	28e. Dete of Inju (Month, De	y Year) 28t	o. Time of Injury	28c. Injur Wor	y et k?	8d. Describe ho	w Injury occur	red	
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within 24 hours after death.  To the Funeral Director: After t completely filled in by the funeral Medical Certification:	2	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	f exeminetion							
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1 0 0 1 ×		29b. Signeture end title of certifier	'Chan			29c. Licens	. 1		9d. Dete signe		
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		30. Neme end eddress of person wh	completed cause of d	leeth (Item 23	e) (Type, Print)					1	
		DR-1 AHMOD	DALIKE	DAL	SISF	RIRI	Tours	AVI.	10/100	O. CAR	SYLAN
State Registrar		DR-NAHOO 31. Date filed (Month, Day, Year)	39. Registr	ar's Signeture	SIS F	AIR	Tour	Avz.	10120	U, MA	54 TE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene GOLDIE J. CORBITT Items: 23a part I.27.28a-f per MEO G-752 10/15/97 dh Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1997 Year **Physician** Month OCT. 6, 6:40 AM GOLDIE CORBITT /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 724 LINNARD STREET BALTIMORE 5. Social Security Number If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Deys Hours 1 M & SE 050-44-4154 44 Yrs. Director DEC.24,1952 MARYLAND Usual Residence of Decedent the Maryland 10a. Stata r 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director XXYes 2 No BALTIMORE MD na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 must be 238 724 LINNARD STREET 21229 Funeral UNITED STATES Herra: 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ Xo If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian Black, White, etc. the Medical Examiner filed within 72 hours efter 1 ☐ Navar Married 2 ☐ Married 21215-0020 ò 1 Yes 2√ Yo Specify: Specify: BLACK A XXWidowed 4 □ Divorced "leanten Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind at Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) CHIMS/ SOCIAL 12 th CUSTODIAN SECURITY Maryland 17. Father's Name (First, Middla, Lest) 18. Mother's Name (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be Mental ALBERT HARRIS GOLDIE HENDERSON OL treumatic end l 19e. Informant's Name/Ralationship (Type Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Nem 27 ALBERT HARRIS, SR. AVE. BALTIMORE, MD 21215 4030 Baltimore, WOODMERE 20a. Method of Disposition 20b. Place of Disposition (Nema of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1 X xuriai 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Fration 5 ☐ Other (Specify) 8 DRUID\_RIDGE\_CEMETERY 10-10-97 BALTIMORE, MD 22. Nama and Address of Facility Signature of Funeral Service Licensee Enfer the disease, or complications that clused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest.

AVENUE or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) MIXED DRUG INTOXICATION Examiner Due to (or as e consequence of): Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest Bnd Due to (or as a consequence of): Box 68760. ettending physician for use as the huna Physician/Medicai Due to (or es e consequence of): P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 'n 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy peen has page 2 this certificate 1 Yes 2 No of Vital Be 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home MResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 2 IXXYes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Division 5 Pending investigation ours effer deet.

N Director: Ah.
In by the fur-Attending 1 Naturel Injury 1 Yes 2XXNo 6:30 found 2 Accident 10/6/97 found subject ingested drugs 3 ☐ Suicide 28e. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify)

6 XXCould not ba

4 Homicide

29a. Cartifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 724 Lennard Street,

Baltimore, Md. 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifian MI

29c. License number O.C.M.E

29d. Data signed (Month, Day, Year) OCT. 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Radentz 5. 111 Penn Street, Baltimore, Maryland 21201 Stephen 31. Date filed (Month, Dey, Yeer)
OCT 1 (

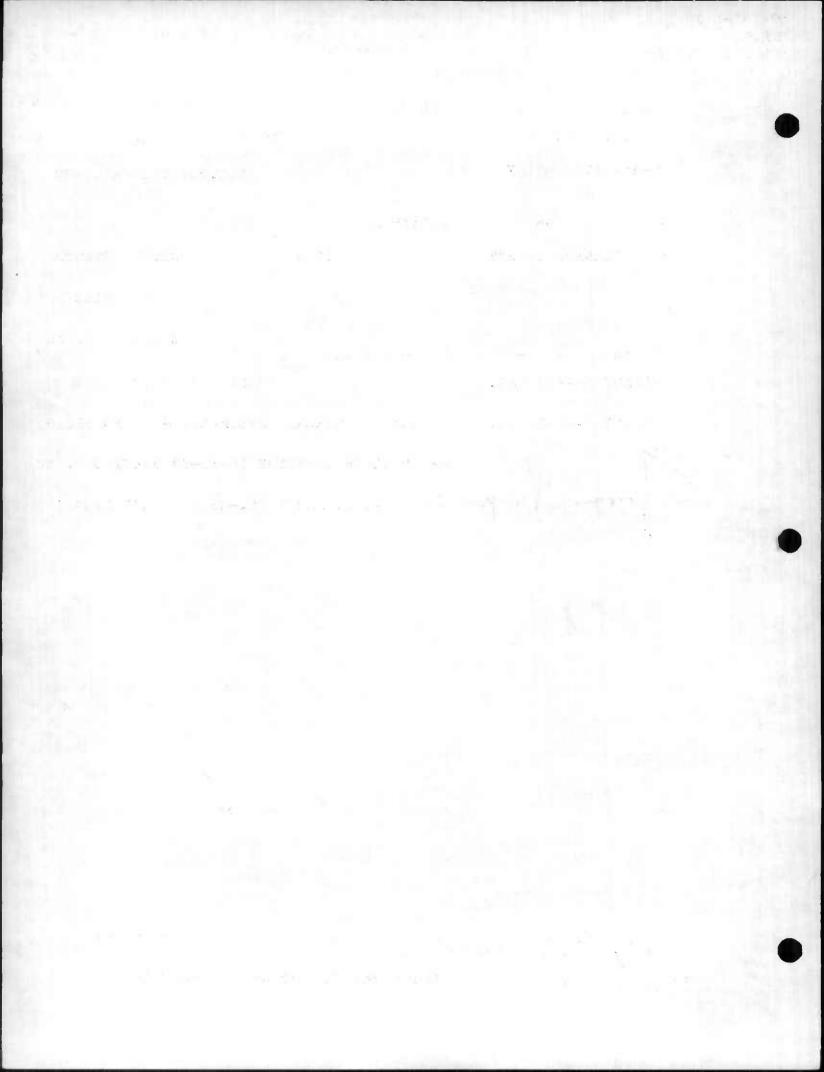
State Registrar

Medical

32. Register's Signature. Pulia Davidson-Randelle 10

found at home

To the Hospital or within 24 hours of To the Funeral D



Physiciar		1. Decedent's Name (First, Middle, Les	t)		, Crimot	ate of	Death	2. Date of D	Reg. No.		3. Time of Death
/Medica	_	Laurie C	ummino	es				OCTO be	Day	Year	0635
xamine neral	r 4	a. Facility Name (If not institution, give Carton - University Social Security Number 6. Security Number 1)	ty of Md.	Medin yrs. lest birthd	Month	ler 1 Year	Balti If Under 24 H Hours M	more		nty of Deeth	place (Stete or Fore
tor	1	251-01-6266  Jsuel Residence of Decedent	рм <sub>2П Р</sub> 80	112	•			NOV Z	4,1916	MAN	Ming, s.c.
		0e. State 10b. County	10	c. City, Town or							10d. Inside City Limi
Directo	1 2	MARYLAND  Oe. Street and Number		BALTI							1 X Yes 2 □ 1
		5336 PERRING PAR	ONMV			ip Code			10g. Citizen o	of What Cou	ntry?
hy Funeral		1. Marital Status  1. Never Married 2. Married 3. Widowed 4. Divorcad	12. Was Decedent Ever Armed Forces? 1  Yes 2 No it Yes, Give Year or Dates:	r in U,S. 1	3. Was Dec If Yes, sp		dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	0- 14. F	lece - Ameri liack, White,	
Pa4	2	15. Decedent's Edu	ucetion	16e. De	cedent's Us	uai Occup	pation		16b. Kind of		
Completed	2	(Specify only highest gred Elementary/Secondery (0-12) 12	College (1-4or 5+)		ive kind of w e. DO NOT ABOREF		during most of v		NATIO	NAL G	CALL.
To Be	ם ב		MINGS	405.14	a Nice at Andrew	(0)	ALICE	CUMM I	NGS		
		19a. Informent's Name/Reletionship (7) BERNARD CUMMINGS						Rurel Route Number			Octobe) AND 21239
		Oa. Method of Disposition	2	Ob. Place of Dis		ame of		Date	20c. Locatio		
		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		CEDAR				10/9/97	BROOKL	YN, M	ARYLAND
Olice	2	21. Signeture Affaineral Service Licens	· 21		ESTEP	BROT	HERS HU	NERAL HO	ME, P.A		
	1	23a. Pert1. Enter the 3 sase, or combi shock, or heart latture. List only o	W. Cote	/	1300 E	EUTAW	PLACE,	BALTIMO	RE, MAR		21217 Approximete
iner	ir d	mmediate Cause (Finel disease or condition esulting In death)	Acus	e mycs	endi	): )	inforce		specie	-/,	Interval Between Onset end Death 5 minus 5 43
edical Examine	Sit oOtt	Sequentially list conditions, any, leading to immediate suse. Enter Underlying cause (Disease or Injury nat initiated events esulting in death) Lest	c. Due	to for as a cons	mol	11itu					1042
			d. Caehr	u rascalo	V (	2 00/	clam +	1		i	
2				t resulting in the		cause ch	en in Part I			ontribute to	the causa of deat
y Physician/M	Pi	Decabitus VI			e underlying	cause giv	on arranti.		Yes 2 No		bebly 4 Unkno
þ	-				e underlying	cause giv	on arr arr.	1 🗆		3 Pro	
Completed by		Decabins VI			e underlying	cause giv		1 □ 24a. Was peri	Yes 2 No	3 Pro	ere eutopsy findings allable prior to mpletion of cause
Be Completed by	26	Decobines via	ans			Oth	26. Place of D	24a. Wat perf	s en autopsy primed?  Yes 2 No	24b. W ev co of	ere eutopsy findings allable prior to mpletion of cause death?
To Be Completed by	25	Decabing VI	cons	2□ ER/Outpat	ient 3 D	DOA Other	26. Place of D	24a. Was perf	s en autopsy primed?  Yes 2 No	24b. Way co of	ere eutopsy findings allable prior to mpletion of cause death?
Certification: To Be Completed by	25	5. Was cese reterred to medical examiner? 1 Yes 2 No 7. Menrer of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	dospital:  1  Inpatient  28a. Date of Injury (Month, Dey Yea  28e. Pleca of Injury - building, etc. (Sp	2 ER/Outpat 28b. Time Injury At home, tarm,	tient 3 D e of y M street, facto	OOA Other	26. Place of D er: 4 Nursing y et k? Yes 2 □ No	24a. Was perf	Yes 2 No sen autopsy ormed?  Yes 2 No one) Idence 6 C how injury occ  Street and Nur wri, Stete)	24b. W av co of 1[  ther (Specification) and or Rural and or Rural	ere eutopsy findings allable prior to mpletion of cause death?  Yes 2 No  Yes 2 No
Certification: To Be Completed by	25	5. Was cese reterred to medical examiner?  1  Yes 2  No  7. Menner of Death 1  Natural 5  Pending investigation 3  Suicide 6  Could not be determined  9a. Cartifier 1  Cartifying Phys	Hospital: 1 ☐ Inpatient  28a. Date of Injury (Month, Dey Yea	2 ER/Outpat 28b. Time Injury At home, larm, secify)	street, facto	OOA Oth 28c. Injun Word 1 1 ry, offica	26. Place of D er: 4 ka Nursing (et k? Yes 2 □ No	24a. Was perf	Yes 2 No sen autopsy primed?  Yes 2 No one) Idence 6 Chow injury occ  Street end Nur win, Stete)	24b. W av co of 1[  Other (Specification) unred	death?  Yes 22No  Y)  al Route Number,
To Be Completed by	25	5. Was cese reterred to medical examiner? 1   Yes 2   No   7. Menner of Death 1   Natural   5   Pending investigation 3   Sulcide   6   Could not be determined	lospital: 1 Inpatient 28a. Date of Injury (Month, Dey Yea 28e. Pleca of Injury building, etc. (Sp	2 ER/Outpat 28b. Time Injury At home, larm, secify)	street, facto ath occurred investigation	ODA Other 28c. Injun World 1 Try, offica dat the time, in my oper.	26. Place of Der: 4 IZ Nursing yet k? Yes 2 □ No he, dete and place oinlon, death occur on number	24a. Was perf	Yes 2 No sen autopsy primed?  Yes 2 No one)  Idence 6 Co how injury occ  Street end Nur wri, Stete)  cause(s) and r date and place 29d. Date sign	24b. W av co of 1!  other (Specifi urred  manner as s a, and due to	ere eutopsy findings allable prior to mpletion of cause death?  Yes 22No  Yes 2No  A Route Number, tated.  to the cause(s)  Dey, Year)

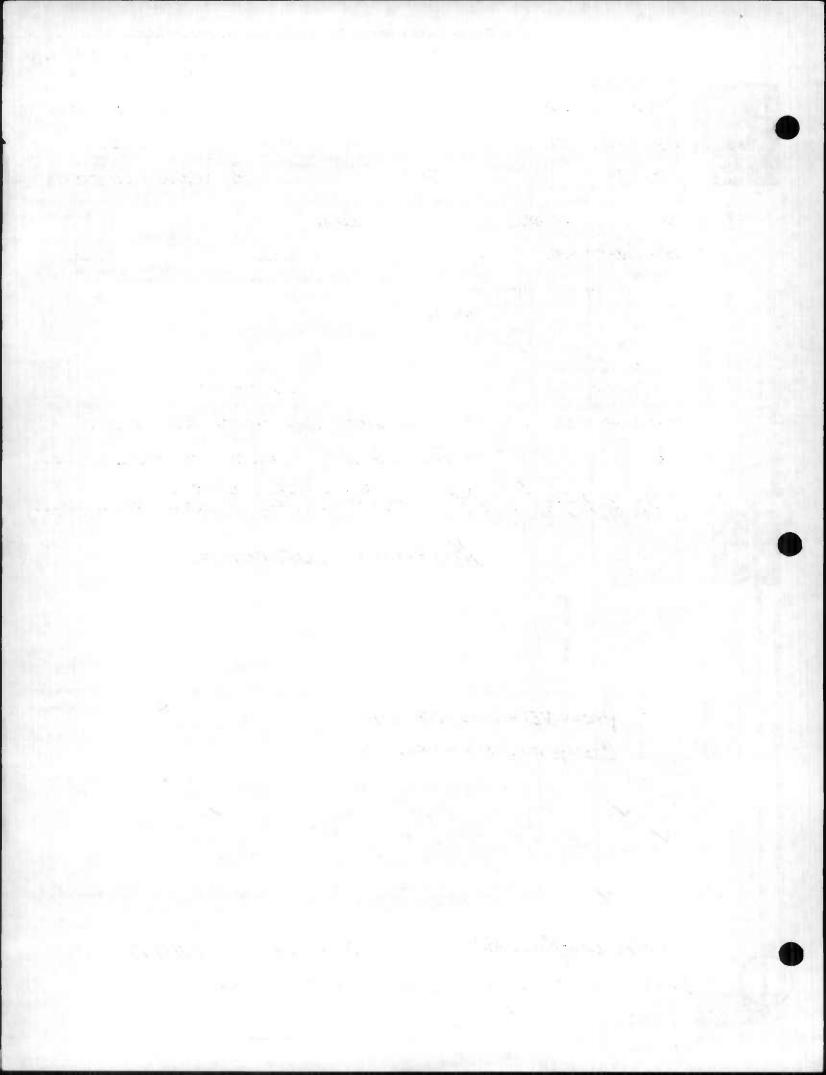
Show when I have

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 3 Time of Death **Physician** THOMAS ANTHONY DEBRIDGET 11:30pm /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 7506 DURWOOD ROAD DUNDALK BALTIMORE if Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** Deys Hours 1€M 2□F 042-22-0458 Yrs. Director 68 JUNE 19,1929 CONNECTICUT Usuei Residence of Decedent 10a, Stete 10b. County 10c. City. Town or Location 10d. inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD BALTIMORE DUNDALK 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 238 7506 DURWOOD ROAD 21222 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 'natural', or items 11. Maritei Stetus 14. Rece - American Indien, permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health end Mental Hygiene. Important: if Item 27 is merked other than "natural, or ite any finlury or other traumatic event, the Mental Examine. 1 ☐ Yes 2 ☐ No
if Yes, Give
Year or Detes:
68 71 1 Never Married 2 Married Maryland 21215-0020 1□ Yes 2□No Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SAMPLE MAKER G A F ROOFING 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be ANTHONY DEBRIDGET DOROTHY FRANCO 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SHARON DEBRIDGET / WIFE 7506 DURWOOD ROAD DUNDALK, MARYLAND 21222 Baltimore, 20b. Piece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriei 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) PARKWOOD CEMETERY OCT. 10 BALTIMORE, MARYLAND 22. Name end Address of Fecliity any ir CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224 23a. Pert1. Enter the disease of complications that caused fr shock, or heart feilure. List only one cause on each line. et caused the death. Do not enter the mode of dylng, such es cardiec or respiretory Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting In death) CARDIAL INFARCTION Examiner Due to (or es e consequence of): Examiner the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): physician a Box 68760, Physician/Medical the Due to (or es e consequence of) ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown YELONEPHRITIS, DIABETES þ Records, 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed CONGESTIVE HEART FAILURE 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 MesIdenca 8 Other (Specify) Certification: To this 27. Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28c. injury et Work? After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hou... the Funeral Dis... 4 Homicide 11 certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner as stated. To the Funer completely fil 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stelled. within 2 29b. Signeture end title of 29c. License number 29d. Dete signed (Month, Dey, Year) 037304 97 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) MARCSHIFFMAN, 31. Date filed (Month, Dey, Year) 2809 BOSTON ST BALTIHORE ND ZIZZY 32. Registrer's Signeture State

104 DHMH 16 Rev 6/95

Registrar

LO +VA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 30725 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 5 per FH G-757 3/4/98 dh 1. Decedent's Neme (First, Middle, Lest) 2. Date of Deeth 3. Time of Deeth Month **Physician** 1: 10 AM 6 /Medical 4b. City, Town, or Location of Death 4a. Fecility Neme (If hot institution, give street and number) 4c. County of Death Examiner Glen Burnie Health Care A.A. Mariner If Under 1 Year If Under 24 Hrs. 5. Social Security Number 4947 6. Sex 7. Age (In vrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 213 - 32 - 498
Usual Residence of Decedent Yrs Director Massachusetts the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f showner must be notified at TYP Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1119 Crain Highway USA Funeral 21061 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Raca - American Indian, Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Maryland 21215-0026 Specify ğ 3 NWidowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 4 Secretary U.S. Government 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Be 12 should be to and Mental P Is marked of 2 Walter H. Anderson Dora Lyfe 19a. Informant's Name/Relationship (Type, Print) friend 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traus GRGS. 1416 Gardman Avenue Emma Bright Baltimore, MD 21209 Baltimore, 20a. Method of Disposition

1 Burlal 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Oct 14 Boston, Massachusetts Mt Hope Cemetery 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway ٤, Baltimore, MD 21216 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximata tntervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Coronory artery 10 years Examiner Due to (or es e consequence of) Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): attending use signed by the atte Part it. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evalleble prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 🗆 Yes 2/5 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 28. Plece of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 70 1 Yes 250 No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Patter death.

Director: After I After 5 Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1🚫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ogriffer 29c. License number 29d. Dete signed (Month, Dey, Year) MD 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

1413 ANNAPOLLS ROAD #106, ODENTON MOZIII3

State Registrar

Dalieet

31. Date filed (Month

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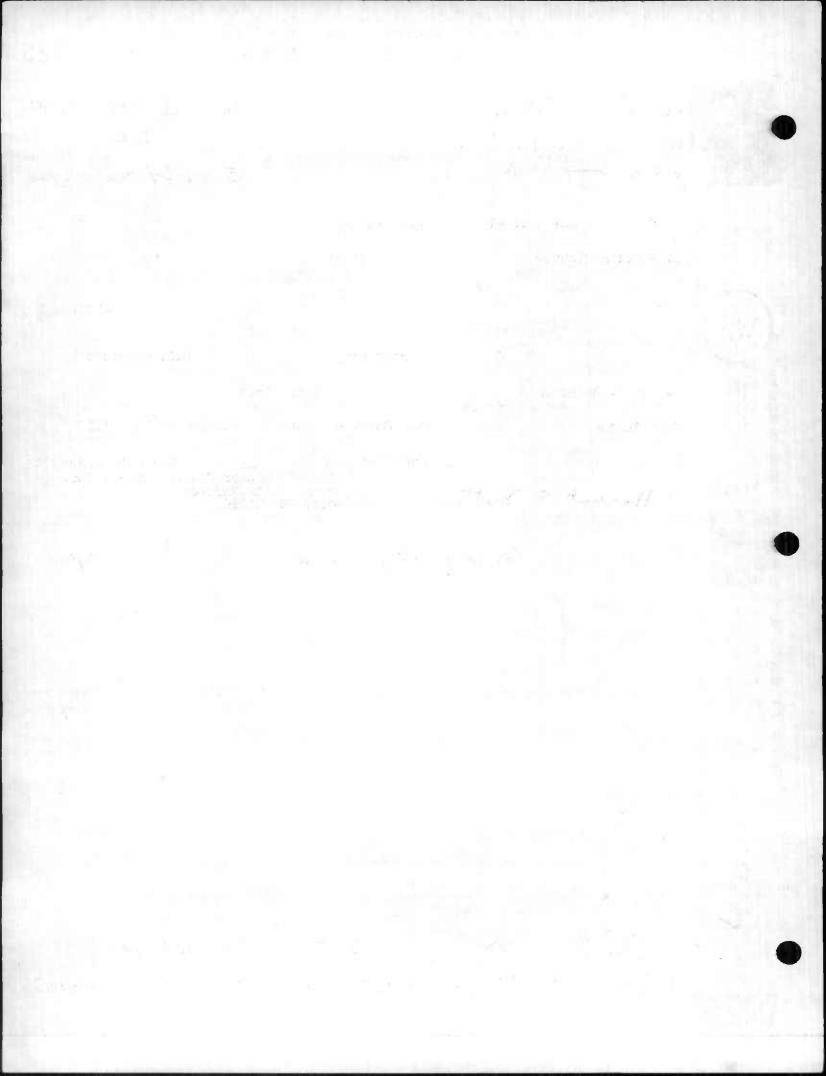
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Day, Year

Sighy

32. Registry's Signature

Fund Davidson-Randall

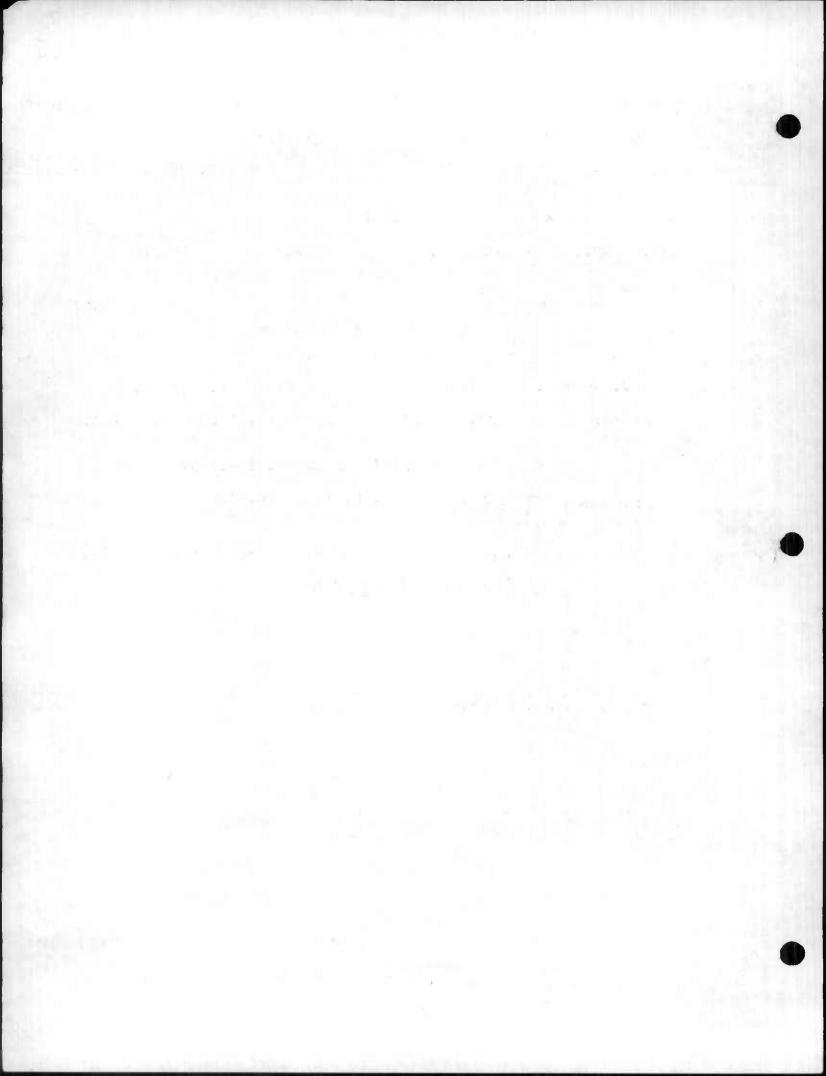


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DESHIELD Month Vaar MREE 5:40 PM oct 1997 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner LIBERTY MEDICAL CENTER BALTIMORE 5 Social Security Number 7. Age (In yrs. last birthday) 74 Yrs. If Under 1 Year If Under 24 Hrs. Dete of Birth (Month Day, Year) FEB 26,23 6. Sex 9. Birthplece (State or Foreign **Funeral** Days 1 □ M 2 🕏 F CPENNSYL VAN JA 217-20-3881 Director Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Director BALTIMORE ty∑yYes 2 □ No na 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 1717 DRUID PARK LAKE DR. 21217 UNITED STATES Herris 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Detes: Never Married 2 Married 8 1 Yes 2 No Specify: by Specify 3 ☐ Widowed 4 ☐ Divorced "natural". BLACK Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filled within Pan Pan NORTH Elamantary/Secondary (0-12) College (1-4or 5+) 8 th SECRETARY/ CLERK CAROLINA MUTUAL Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 8 REV. ZORAH B. DE SHIELD SARAH E. TAYLOR traumatic 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) settment of Health an important if them 27 is n any injury or other once. MATTHEW JOHNS JR. SPRINGDALE , BALTIMOREMD 21216 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State XXXBurial 2 Cramation 3 Removal from State 4 □ Donation 5 □ Other (Specify) FREEDMAN'S METH. CH. 10-11-97 TYASKIN, MD 21. Signature of Funeral Service License 22. Neme end Address of Facility WM . C. MARCH FH.-4300

23a. Part1. Entur the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or earl failure. List only one cause on each line. WABASH AVENUE Approximate interval Batween Onset and Death Physician CONGESTIVE HEART FAILURE MANY /Medical Immediate Causa (Final disease or condition resulting in death) YEAR S Examiner rew Renal FAILURG The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue physician the buriel Box 68760. Physician/Medical Due to (or es e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23h. Did tohacco use contribute to the cause of death? P.O. signed by the ALVULAR HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown by Division of Vital Records, should by Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performad? completion of cause of death? 1 Yes 2 9 No 1 ☐ Yas 2 ☐ No this certificate I or Attending Physician: efter death.
Director: After this certifica Be 25. Was casa raferrad to medical 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residanca 8 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled i 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, daath occurrad at tha time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shar D19668. M-D, LIBERTY MEDICAL Center. Baltimore. MD 30. Name and address of person who completed cause of death (Itam 23a) (Typa, Print) R.M.SHAH 32. Registyr signalors State

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** EVA MAXINE EVERETT ntober 1 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FALLSTON FALLSTON General HOSPITAL If Under 24 Hrs. Hours Min. 5. Sociel Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year) Nov 24, 926 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1□M 2K)F Days 70 Yrs. 215-22-3060 Director MARYLand Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified Director 1 Yes 2 No 28a-f Mo. Harsord Jarrettsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1406 CHROME RD 21084 Funeral USA thorns: 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Raca - American Indian, Bleck, White, etc. the Medical Examiner 1 Never Married 2 Married b 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than the Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Cook CATERER 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 0 Cockerham Laura Jones James 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) . Pages 1 and 2 riportant: If item 27 Kichard Everett 1406 CHROME HILL KD. carrettsville, MD. 21084 husband 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State CCT 13 ö 4 Donetion 5 Other (Specify) MT. ZION United METHODIST 1997 Bel AIR, MO 21. Signature of Funerel Service Licanse 22. Name end Address of Fecility Forest Hill, MD. 23e. Pert1. Enter the disease, or complication in thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one circum on each line. EVANS FUNERAL CHAPEL BELAIR 3 NEWPORT DR Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) yo Clind Examiner scle The law requires that the death certificate be executed 0400 Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24b. Were autopsy findings eveileble prior to completion of cause of deeth? page 2 should 24a. Wes en eutopsy performed? certificate hes 1 TYes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Aftert 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end manner steted. Medicai 29a. Certifier (Check only 29b. Signeture and tipe of pertiner 29c. License number 29d. Dete signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) oliesti, Busness Certen 31. Dete filed (Month, Dey, Year)
OCT 1 0 1997 State Registrar

DHMH 16 Rev 6/95

June Ledgerham

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: 17 per K.B G-752 10-9-97 eoh 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 0240 AM Baby Boy Elliott 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Union Memorial Hospital Baltimore City Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1₩ 2□ F Days Yrs. none Sept 23, 1997 Maryland Usuai Residence of Decedant 10c. City, Town or Location Baltimore County 10a State 10b. County 10d. insida City Limits Maryland Baltimore 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6318 Craigmont Avenue 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marriad 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Dacadent's Usual Occupation (Give kind of work dona during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) none-infant none 17. Fether's Neme (First, Middle, Last) VAN MICHAEL ELLIOTT 18. Mother's Nama (First, Middle, Melden Sumame) Nora Yvonne Elliott Knight Nora Yvonne Elliott-Knight 19b. Malling Addrass (Straet and Number or Rural Route Number, City or Town, State, Zip Code) 6318 Craigmont Avenue, Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) Nora Yvonne Elliott-Knight 21228 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 ☒ Other (Specify) in State <sup>22</sup>Name and Address of Facility State Anatomy Board, 655 W. Baltimroe Street Joseph B. Van Sant Baltimore, Maryland 21201 23a. Pertf. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximata Intarval Batween Onset and Death immediate Cause (Final hour disease or condition resulting in death) 1 hour tailur spirator Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Due to (or as a consequence of) Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 20 No 1□Yes No 25. Was cese referred to medical 28. Place of Death (Check only one) 1□Yes 2⊠ No 27. Manner of Death

**Physician** /Medicai **Examiner** 

**Physician** 

/Medical

**Examiner** 

**Funerai** 

Director

28a-f show

5

Items 23a death

"natural", or

should be filed within 72 hours on the Mental Hygiene.

marked other then "natural", or

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othy any follury or other traumatic event, 2008.

21215-0020

altimore, Maryland

Director

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Completed

traumatic event, the Medical Examiner must be notified at

ettending physician I for use as the burie signed by page 2 should this certificate director, After To the Hospital or Attendit within 24 hours efter deeth.

To the Funeral Director: A completely filled in by the f

Physician/Medical þ Completed Be Certification: To

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Panding Investigation

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and fitte of certifier

6 Could not be determined

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Michelle Roberts. 32. Registrer's Signature

Union Monoral Hosp. 201 E. Univ. Pkwy.

Registrar

Medicai

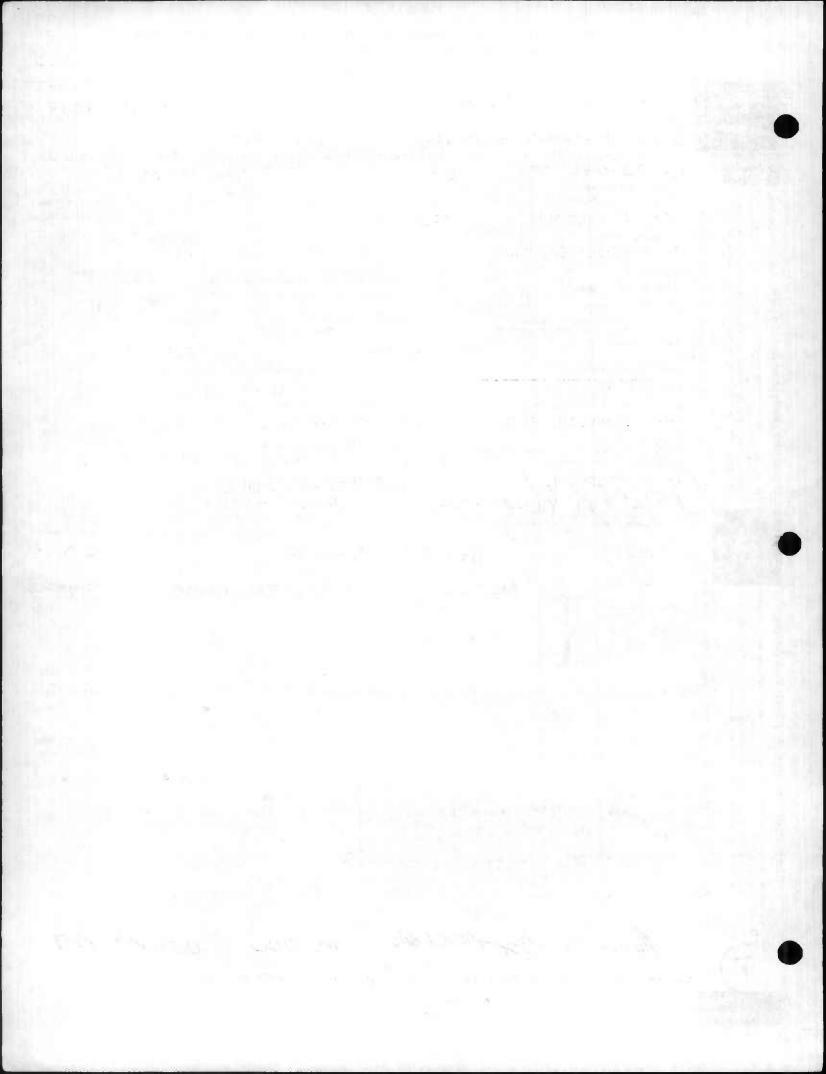
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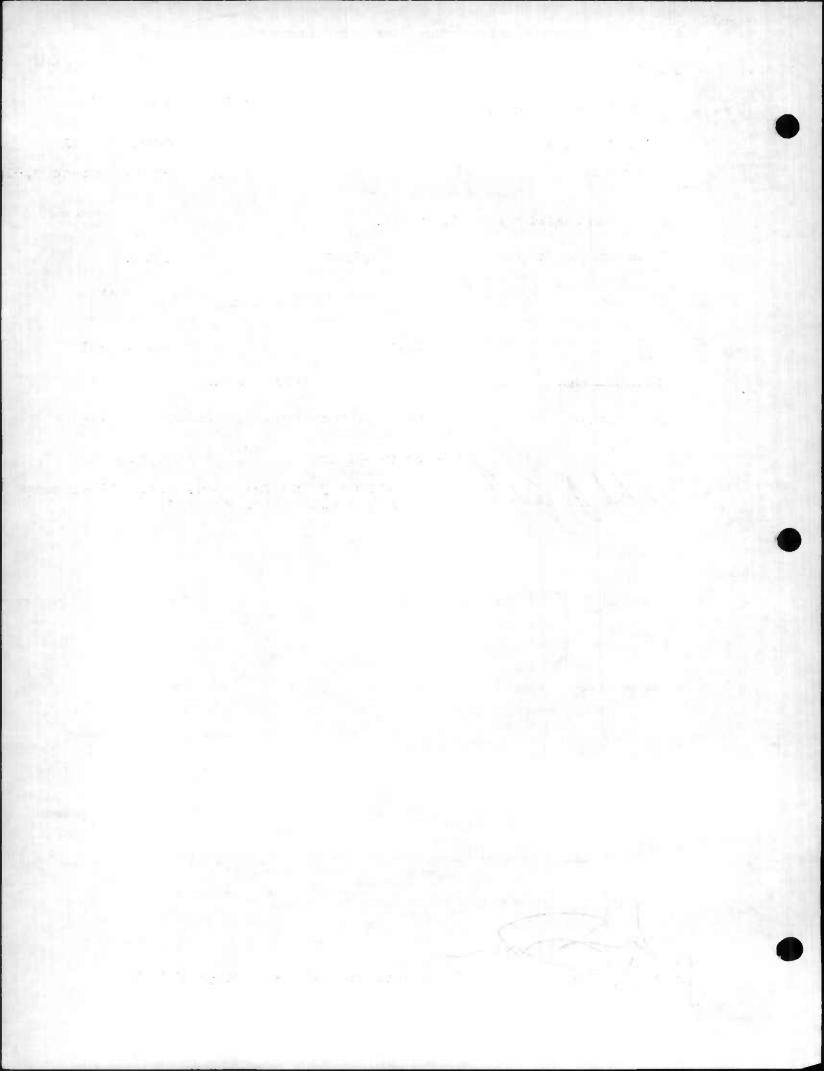
State of Maryland / Department of Health and Mental Hygiene 97

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Director	10e. Street end Number				10f. Zip C					10g. Citizan of	Whet Coun	try?	
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cal Examiner	shock, or heart failure. List only of Immadiata Causa (Final disease or condition rasulting in death)  Sequentially list conditions, if any, leading to immadiate causa. Enter Undarlying Causa (Disease or Injury that initiated evants		Due to (or as a Due to (or a) Due to (or a	a consequence	uence of):  AD uence of):			ARC	ino	MA		Interval Batwe Onset end De  2 Day  5 yes	y T
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edicai	29a. Certifiar (Check only one) 1 € Certifying Physical Examile (Check only one)	nician: To the best nar: On the basis of and manner s	of axaminetion a	ga, daath ind/or Inve	occurred at t estigetion, in	ha tim my op	a, date end pinion, deet	d piaca, a h occurre	nd dua to tha	causa(s) and modate and place,	ennar as sta and dua to	ated. the cause(s)	
×	29b. Signature and titia of cartifier	1				canse	number			29d. Date signe		Dey, Year)	
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	30. Nama and address of person who con THOMAS HENNEBRY,	ompiated cause of	deeth (Item 23a ASTERN	) (Typa, F	Print)	IMI	ore .	MD :	21224				
State	31. Data filed (Macth Cay, Year) 10 199	7 32. Ragest	rars Signatura	n- Pan	dell								



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l uneral Director		5. Social Security Number 216-80-6604	6. Sex 126 M 2□ F	7. Age (In yrs. 37	lest birthday) Yrs.	If Under 1 Year Months Days	Hours I	Hrs. 8. Date of B Month, D June	ay, Year)	9. Birthplace Country Wash	e (State or Foreign ington, I
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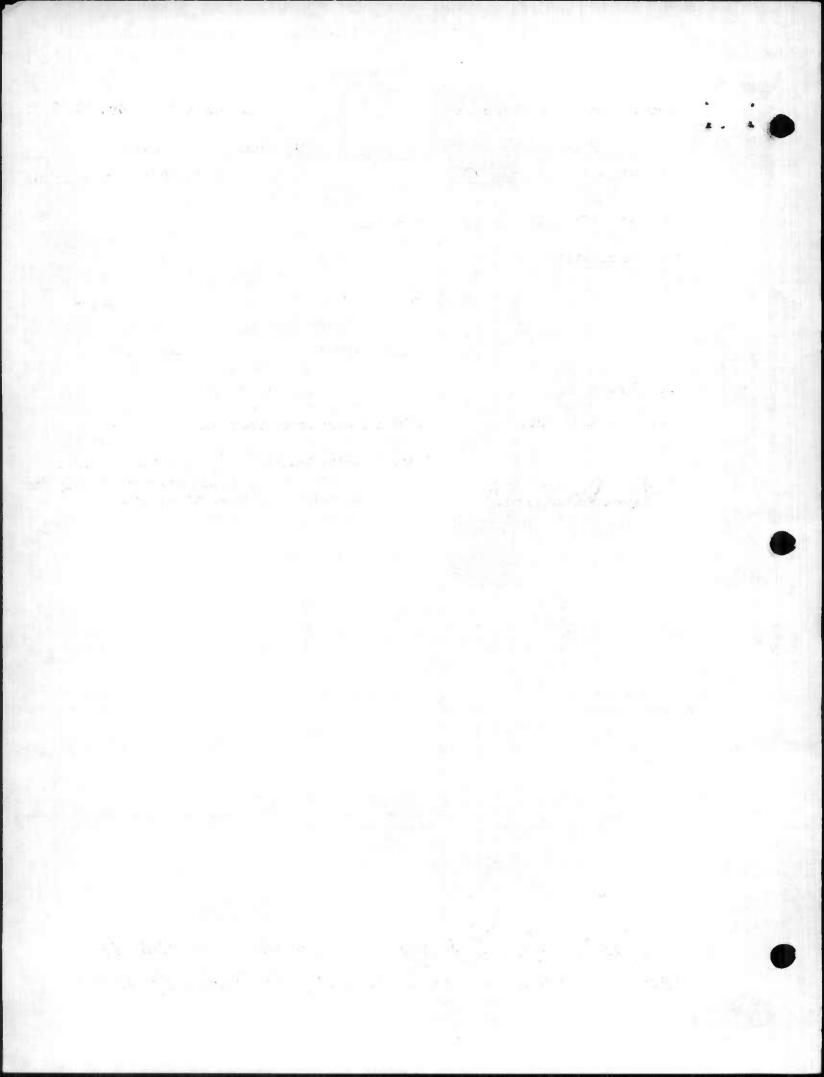
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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				Ce	rtificate of	Death		Reg. No.		,0,0,
		1. Decedent'a Name (First, Middle, L	est)				2. Dete of Dea	ith		3. Time of Death
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	niñer	4e. Fecility Name (If not institution, gi				4b. City, Town, o	r Location of Deeth	4c. County	of Death	
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Funer Direct			Sex 7. Age (In 1⊠ M 2□ F 70	yrs. lest birthdey) Yrs.	If Under 1 Yee Months Deys			(, Year)	Country,	e (Stete or Foreign Virginia
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3a or 28	i Director	10e. Street and Number 5132 Norrisville			10f. Zip Code 2116	1		10g. Citizen of	What Country	?
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Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menia important: If teen 27 is marked any Injury or other traumatic as		12 Buriai 2 Cremetion 3 [ 4 Donetion 5 Other (Special	fy)	Bel Air		1 Gardens	10/7/97	Bel Air		1.559
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Di To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical Ce	(Check only 2 Medical Example 1)	nyalcian: To the best of my niner: On the basis of exan	knowledge, deeth	n occurred et the l	time, date and place	ce, end due to the coursed at the time, of	euse(s) end ma	anner as stete	id. e cause(s)
the the I	Med	one) 29b. Signature and title of certifier	end manner steted.			se number				
5 × 5 0		Signature of Contract	11.1.4	120				29d. Date signe	,	
		- Lyama	1, Uniles	1 MD	$\nu$	25567			3/97	
			completed cause of death (	Item 23a) (Type, 101 So.	Print)	it No	Freedon	- Pa	17211	0
	101	31. Date filed (Month, Day, Yeer)	32. Registrer's S		givad 1	, reser	1 Scale	7,14.	1124	
- :	tate	OCT 1 0 1	7 4 1	'i 50	1.00					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth **Physician** Gordon tober /Medical 4e. Fecility Neme (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALtimore - 7 Undar 24 Hrs. 9. Birthplaca (State or Foreign **Funeral** Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If tem 27 is marked other than "natural", or items 23a or 28a-f show any or other treams of the show many or other treams to a rottled at any or other treams to a rottled at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Completed by Funeral Director MORE et end Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Daceden If Yes, specify 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No of Hispanic Origin? (Specify Yes or No-Cuban, Maxican, Puarto Rican, etc.) Race - Amarican Indian, Black, White, etc. 1 Navar Married 2 Married 1 Yes 2 If Yes, Giva Yaar or Detes: Baltimore, Maryland 21215-0020 2 1 No 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry memployed Elementery/Secondary (0-12) College (1-4or 5+) 17. Fether's Name (Fi rst, Middle, Lest) 8. Mother's Name (First, Middle, Meiden Sumeme) 19a. Informant's Neme/Reletionship) (Type, Print) 20b. Place of Disposition (Name cematary, cremetory or any 20e. Method of Disposition

1 Buriel 2 Cremation 3 Removel from State permit. Page Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sarvica Ligense 23a. Part1. Enter the disease, or complications that mused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one ceuse on such line. **Physician** /Medical Immediete Ceuse (Finel disaesa or condition rasulting In death) Intravascular Coaquepathy **Examiner** Due to (or es e consequença of): Physician/Medical Examiner SIS burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): ng physician a Division of Vital Records, P.O. Box 68760. Due to (or es e consequance of): use been signed by the atter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wera eutopsy findings available prior to complation of causa of death? 24e. Was en autopsy performed? page 2 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending after death. Director: A 1 Yas 2 No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) filled in by 4 Homlcide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) end manner stated. 29a. Certifier To the 29b. Signature and title of certifi 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who dompleted cause of death (Item 23e) (Type, Prigt)

DHMH 16 Rav 6/95

State

Registrar

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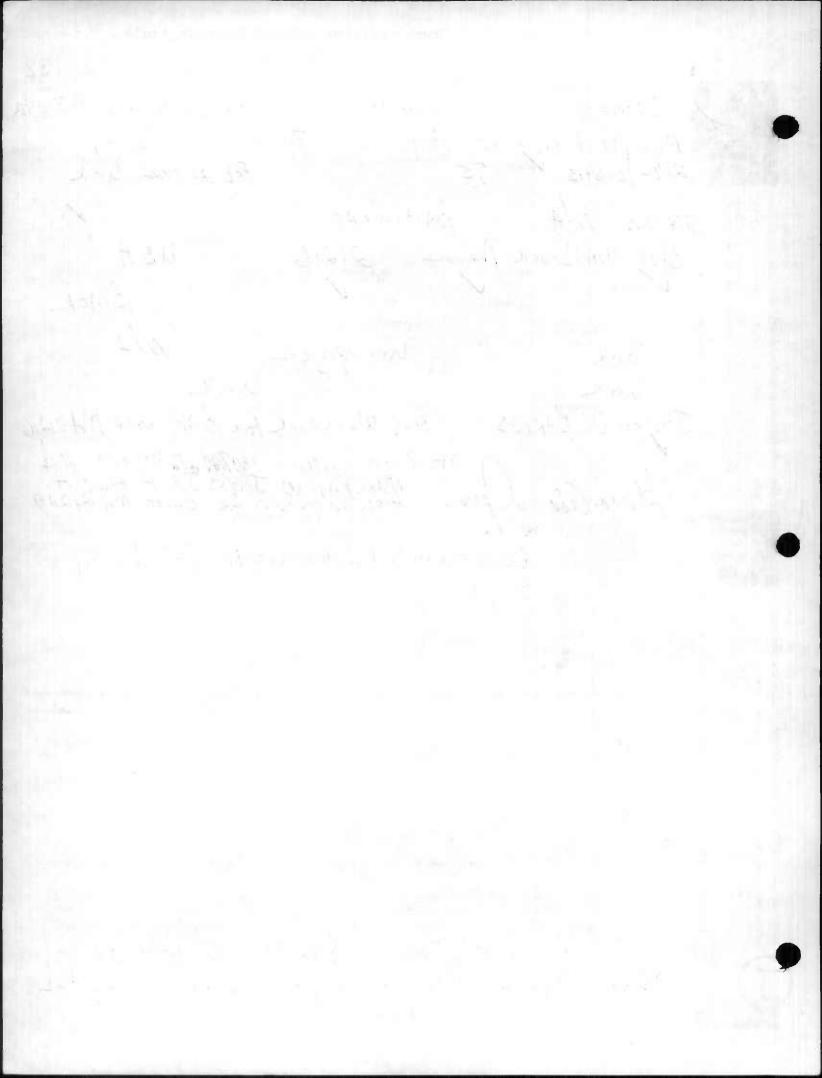
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0 1997

32. Degistrar's Signature

his Davidson

31. Dete filed (Month,



State of Maryland / Department of Health and Mental Hygiene 0.7

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				Certificate of	Death	Re	g. No.		00/33
Physiciar /Medica			GRIMES			2. Date of Deat Month OCTOBER	Day	Year 797	3. Time of Death 12:40 A/
Examine		4a. Facility Name (If not institution, go HARBOR HOSP			4b. City, Town, or BACTI	mare			more
Funeral Director	- 1		Sex 7. Aga (In yrs. last)	yrs. If Under 1 Yea Months Days		8. Date of Birth (Month, Day, 2-18-	Yaar) 1935	9. Birthple Count	S. C.
with the Maryland or 28a-f show be notified at	ctor	10a. State 10b. County  Md N	A Bal	wn or Location Amore				10	d. Inside City Limits
ath with the 23a or 28	Funeral Director	222 Norfoll	Street	10f. Zip Code 2/2			Og. Citizen of W	5.A	
urs	6	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give / Yaar or Datas:	13. Was Dacedant of If Yes, specify Cult		pecify Yes or No- o Rican, atc.)		- America k, White, e	
within 72 ho ene. then "netur he Med call	Сотріете	15. Decedent's Elementary (Specify only highest gi	rade completed)  College (1-4or 5+)	a. Decedent's Usual Occu (Give kind of work done life, DO NOT use retin	e during most of wor ed)	king	16b. Kind of Bu	sinass/Ind	ustry
d out	o se co	17. Father's Name (First, Middle, Las	NA	Seam tre		ne (First, Middle, M			
ges 1 and 2 shout of Health and N		19a Informant's Name/Relationship  Am & W · Bag    20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 (	ey -Son /	of Disposition (Neme of tery, cremetery or other pla	rspoon A	Date 2	Baltu. 20c. Location	State, Zip Mel Z City or Tov	2/2/2 vn, State
permit. P Departme Importan any Injur		21. Signature of Funeral Service Lice  22. Signature of Funeral Service Lice  23. Part1. Enter the disease, or con	le Cork	122, Name and Addr March F. 43	ess of Facility H. West Od wal	tash ,	Balto,	nd	2/2/5 <sup>-</sup>
Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart feilure. List only Immediata Cause (Final disease or condition	one cause on each line.  SEPTIC			,	,		Interval Between Onset and Death  DAYS
à		resulting In death)		a consequenca of):	NTRAVAS	SCULAR	COAGO	CATI	on 2 DA
be axecuted clan and bunial-transit		Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Diseese or Injury that Injuryated avenue.	Due to (or as	a consequenca of):					
death certificate be assected e attanding physician and of for use as the bunal-transition.	= 1	that initiated avents resulting in death) Last	Dua to (or as a	consequence of);					
	iysicia	Part II. Other significant conditions		in the underlying cause g	iven in Part I.				the cause of death
Se de de de de de de de de de de de de de	2		LMONIA			24a. Was ar	autopsy	24b. We	re autopsy findings
2 S S D	n biere		POSITIVE			perform	ned?	ava	ilable prior to apletion of cause eath?
ysician: The lists certificate hadirector, page	0	25. Was case referred to medical examiner?	NARY ARTE		thor	ath (Check only on			Yes 2 No
After this funeral di	-  -	1 Yes 2 No  27. Mennes of Deeth  1 Neturel 5 Pending investigation	(Month, Day Year)	. Time of 28c. Injury		ome 5 Reside			)
r Attendar death rector: by the		3 ☐ Suicide 6 ☐ Could not le determined		farm, street, factory, office	1	28f. Location (St.	reet and Number. State)	r or Rural	Route Number,

29a. Certifier (Check only one)

29b. Signature and title of con-

Medical

New and address of person who completed cause of deeth (Item 23a) (Type, Print) 3001 SOUTH HANOUER STREET HARBOR HOSPITAL CENTER BACTIMORE MD 21215 State Registrar

RESIDENT

INTERNAL MEDICINE

**DHMH 16 Rav 6/95** 

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

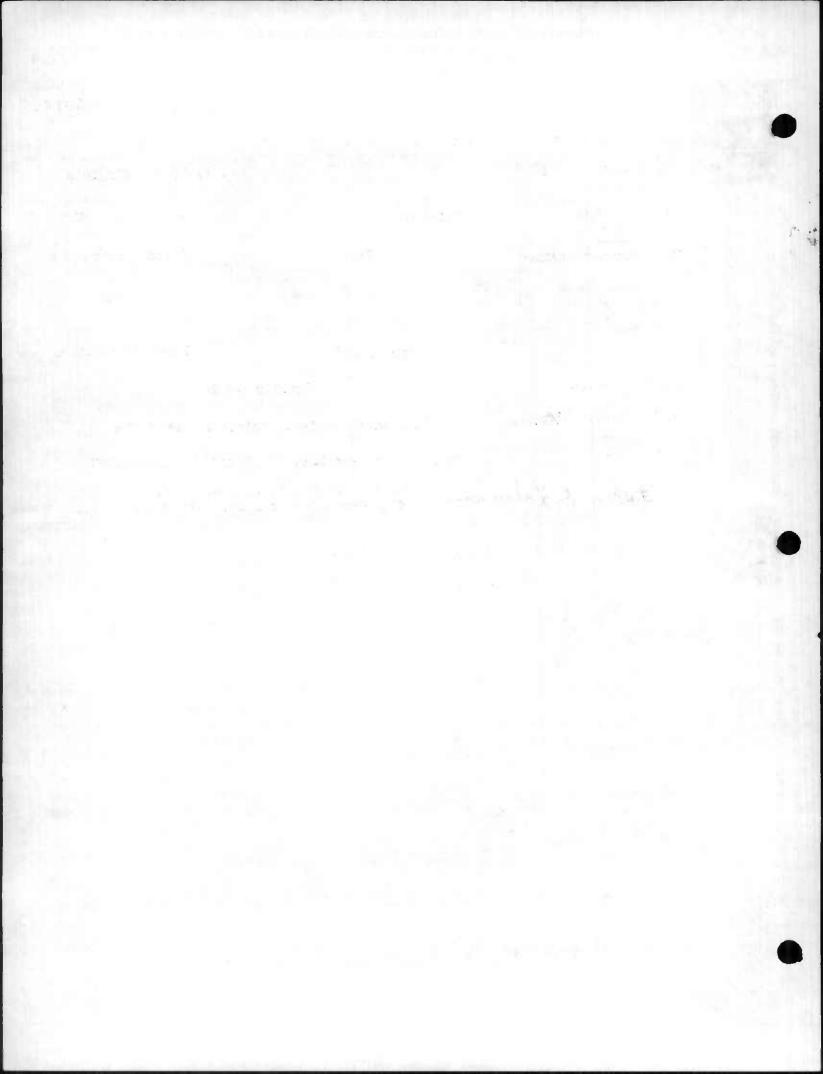
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State of Maryland / Department of Health and Mental Hygiene Q 7

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						Ce	rtificate	of Dea	th		Reg. No.	, ,	0010
Dhuniai		Decedent's Neme (First, Memory)	fiddle, L	ast)	1	- 1	IQUAL.			2. Dete of De Month	eth D <i>e</i> y	Yeer	3. Time of Death
Physicia /Medic		James	6	rordon						October		1997	309 AM
Examin		4e. Fecility Neme (If not insti			)			4b. City	, Town, or	Location of Deeth	4c. Count	y of Deeth	
		University of Mary	landt	ledical Systems	22 South	Green	ne Street	Bal	timor	e	N	V/A	
Funeral Director		5. Sociel Security Number 093–40–2398		Sex 7. Ag	ge (In yrs. les	t birthdey, Yrs.	if Under 1 Months [	Year If Un Deys Hou	der 24 Hrs. Irs Min.	8. Date of Birt (Month, De NOV . 1,	th y, Year)	9. Birthpi Count	iace (Stete or Fore try) (inia
		Usuel Residence of Deceder	it								1340	vilg	IIIIa
yan.		10e. Stete 10b. Co			10c. City, 1	Town or L	ocation					10	0d. inside City Lim
the Marylar 28a-f show notified at	tor	MD N/	A		Balt:	imore	9						1 X Yes 2□1
or 28a-f show	Je l	10e. Street end Number					10f. Zip C	ode			10g. Citizen of	What Coun	try?
23a o	0	2113 Souther	n Av	enue			2121	4			United	Stat	es
homs ?	Funeral Director	11. Meritel Status		12. Wes Decedent	Ever in U,S.	13.			Origin? (S	pecify Yes or No o Ricen, etc.)		ce - Americe	en Indien,
ल ठेड	by	1 ☐ Never Merried 2 ☐ 3 ☐ Widowed 4 【X】Divo		Armed Forces  1 Yes 2  If Yes, Give Yeer or Detes:			1 Ves 24			o Ricen, etc.)		ock, White, e	
n 72 hours "natural", ed cal Ext	Completed	15. Decc	dent's E	ducation	1	6e. Dece	dent's Usuel (	Occupation			16b. Kind of E	Business/Ind	Justry
e + 61	ple	(Specify only n Elementery/Secondary (0-		rede completed)  College (1-4or	54)	life.	e kind of work DO NOT use	done during i retired)	nost of wor	king			
	ПО	12	-/	College (1-40)	34)	Mac	hinist				Stee1	Fabri	cation
s 1 and 2 should be filled t Health and Mental Hygic fam 27 is marked other other traumatic event, it	Be	17. Fether's Neme (First, Mic	die, Las	t)				18. M	other's Ner	ne (First, Middle,	Meiden Sumer	m <i>e)</i>	
Mental Mental arked o	ToB	James D. Gord	don					Es	telle	Smith			
and Men is marke aumatic		19e. Informent's Name/Rele	lonship	(Type, Print)		19b. Maili	ing Address (S			irel Route Numbe	er. City or Town	. Stete. Zip	Code)
Ith ar		Adline Harris	,	Sister									,
itam 27 othar tr		20e. Method of Disposition			20b. Plec	e of Dispo	osition (Neme	of	2. B	altimore	20c. Location		wn State
rages net of I nt: If its iry or or		1 Buriel 2 Cremat					metory or othe	, ,					
		4 Donetion 5 Othe			Gree	-	unt Cre	-		10/9/97	Baltimo	ore, M	ID
Departr Importa inny inje		21. Signeture of Funeral Ser	rice Lice	nsee 1			2. Neme and /		-				
		Stephen	W.	Lohima		Q.	117 Cro	cepner	1 D. 1	Lohrmann	P.A.		01000
		23e. Pert1. Enter the disees shock, or heert failure.	e, or con	plicetions thet cause	d the deeth. I	Do not en	ter the mode of	of dying, such	es cardied	or respiretory er	rest,	· MU	21286 Approximate
Physician	1	SHOCK, OF HEAT TAILUTE.	LIST OFFIS	one cause on eech i	110.								Onset and Deeth
/Madical		Immediete Ceuse (Final		Δ	+-	D	sectio						
Sxaminer :	\$	disease or condition resulting in deeth)		e	, ,			n					
	-			1	Due to (or es	Λ							
nsit a	듣			b. HO			arysm						
and Il-tra	Examine	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury			Due to (or es	e conse	quence of):						
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e as	Me		L	d								1	
attendir tor use	an			U.									
the at	Physician/	Pert ii. Other eignificent con	ditions	contributing to deeth b	ut not resultin	ng in the u	inderlying ceu:	se given in P	ert I.	23b. Did t	obacco usa co	ontributa to	the cause of dear
signed by the a	Ph.	Acute Renal	5	1.0						10	Yes 2 No	3 Prob	ably 4X Unkno
Ine law requires that the death certificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	ricute neval	Pai	lure									
old blu										24e. Wes	an eutopsy	24b. We	ere autopsy finding
should should	Set									репо	med?	con	elleble prior to inpletion of ceuse deeth?
s has	Completed										and to		
										111	es 2 No	1	Yes 2 No
Sertif	Be	25. Wes cese referred to me exeminer?	dicel	Hospital:					lace of Dee	oth (Check only o	ne)		
r this certitic	2	1 Yes 2 No		1 25 Inpatie		/Outpetie		-	Nursing H	ome 5 Resid			)
After funer	0	27. Menner of Deeth 1 Neturel 5 □ Pe	nding	28e. Date of Inju (Month, De	y Year) 28	b. Time o Injury		Injury et Work?		28d. Describe h	now injury occu-	rred	
or: A	Tage	Z LI Accident	estigatio				М	1 Yes 2	2 🗆 No				
rect	=	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	uid not b ermined	200. Piece of in	ury - At home c. (Specify)	, farm, st	reet, factory, o	ffice		28f. Location (S City or Tox		ber or Rurel	Route Number,
s af	Certification:				. (-,,,								
to the house after death.  Yithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral	edical	29e. Certifier (Check only one) 1 Cart 2 Med	fying Pi cal Exa	nysician: To the best miner: On the basis o end manner st	examination	dge, deat end/or in	h occurred et to	he time, dete my oplnion,	e end plece deeth occu	, end due to the orred et the time, o	ceuse(s) end m dete end plece,	enner es ste end due to	eted. the ceuse(s)
om thing	Z	29b. Signeture end title of ce	tifier				29c. L	lcense numb	er		29d. Dete signe	ad (Month, I	Day, Year)
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2		Annel Men	doz	a ragle "	11/			1776	>	LSouth Green	UCLODE	08/1	747
31		30. Name end address of per	-	completed cause of o	leath (Item 23	(Type,	Print)	1. 1-	1 -	3		0.14	2120
1		ARNEL MENDOZI		GLE, MI) Un	iversity	ot Ma	rylandMe	dical Sys	tems 2	LSouth Green	ne Street 1	Seltimo	'e Maryland
Stat	e	31. Date filed (Month, Dey, Y	ear)	a 32. Registr	er's Signeture	9							
Registra	ır	OCT 1 0 1997	V	Julia Day Son	- Randa	2							



State of Maryland / Department of Health and Mental Hygiene

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30735

				Cei	rtificate of	Death		Reg. No.		
100		1. Decedent's Name (First, Middle, Last	)		101		2. Date of Dea Month		Vons	3. Time of Death
Physic /Medi		Wilbur Henry G:	rover				Oct.	Day 5	1997	1:40PM
Exami		4a. Facility Nama (If not institution, give	street and number)			4b. City, Town, or Le	ocation of Deeth	4c. Count	y of Deeth	
		Oak Crest Care Cer	nter			Baltimore	County	Balt	imore	County
Funeral Director		216-10-9116	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt	h y, Year)	9. Birthp	place (State or Forei ntry) LMORE, Md.
and *		Usual Rasidenca of Decedent  10e. State 10b. County	10c. C	ity, Town or Lo	ocation				T	10d. Inside City Limit
death with the Meryland ms 23a or 28a-f show rmat be notified at	ō	Maryland Baltimor								1 ☐ Yes 2 X N
the M	Director	10e. Street end Number	.e Da.	TTTIIIOTE	County			10- 02:	148	
E 0 8					10f. Zip Code			10g. Citizen of		itry
s 23	eral	8800 Walther Blvd	. Apt. 3202	10 10 1	2123		neify Ven ex Ne	U.S.	A . ce - Americ	ana Indian
21215-0020 d within 72 hours effer duples. I then "netural", or frem the Medical Evantines.	by Funeral	11. Marital Status  1 □ Never Merried 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 X No If Yes, Give Yeer or Dates:		was becedent of If Yes, specify Cul 1 ☐ Yes 2 🂢 No	Hispenic Origin? (Spoan, Mexican, Puerto Specify:	Rican, etc.)	Speci	nck, White, fy:	
2 ho	Completed	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occu	pation		16b. Kind of E		
Phin 7	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retin	pation during most of work ed)	ang			
2121 ed within ygiene. er then	Ю	8th.	n/a	Carpe	enter			Self-En	ploye	ed
e filed al Hygi other	Be	17. Father's Neme (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maidan Suma	me)	
Maryland d 2 should be file th end Mental Hy 7 is merked oth traumatic event	To	James Wilbur Grove	er			Wilhelmi	na Reie	r		
re, Maryle s 1 end 2 should Heelth end Mer tem 27 is merke other traumatic		19a. tnformant's Name/Relationship (T)	rpe, Print)	19b. Maiiir	ng Address (Stree	t and Number or Rur	a <i>l Rou</i> te Num <i>be</i>	er, City or Town	, State, Zip	Code)
E - 00 -		Mrs.Gladys Reed ([	Daughter)	8800	Walther	Blvd. Apt	.3202 B	altimor	e.Md.	. 21234
0 0 0		20a. Method of Disposition 1     Burlai 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	removal from State	Place of Dispo cemetery, cren	sition (Name of matory or other pla	ace)	Date	20c. Location	- City or To	own, State
Baltimo permit. Pege Department of Important: If any Injury or sace.		21. Signature of Funeral Spaylos Vicens	1		hodist C		0/8/9/	FUIK, ME	тутаг	nd 21051
Ball permit Department Impon		274				sahn Fune	ral Home	е		
		670	assanx	/ 1	1750 Bel	air Road	Kingsv:	ille. M	aryla	
		23a. Part1. Enter the disease, or compleshock, or haart failure. List only or	ications that caused the dea ne cause on each line.	th. Do not ant	er the mode of dy	ing, such as cardiac	or raspiratory ar	rast,	1	Approximata Interval Between
Physician				0 0	0 0	~ ~ <del>*</del>			i	Onset end Death
/Medical Examiner		immediate Cause (Final disease or condition	· Sm	11	Brunel	Obelre	ution		į	2 meder
Lamine		resulting in death)	Due to (	or as a consec	quence of):		0030			20 -01-0
D #	Examiner		add	D DI M	1 -				i	
68760, ficete be executed physician end street burial-transit	E	Sequantially list conditions,	Due to (	or as a conseq	yenge of):	0 1			i	
o e e e e e e e e e e e e e e e e e e e		Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury	Dian	1 2	4 0,0	n 16 0. 1/2			1	
68760, ficete be ex physician st the buria	edical	that initiated events resulting in death) Last	Due to (c	or as a conseq	dence of	- Henry			1	
x 6876( ertificate be ling physicia	Med	Tooding it dustry East								
			d						1	
. 0 0 0	Physician	Pert II. Other significant conditions cor	ntributing to death but not ras	sulting ipythe u	nderlying cause/g	iven In Part I./	23b. Did t	obecco use c	ontribute to	o the cause of deat
P.O at the d by th	hy	7).14	m. 00 to	Mari	6	1. 1. 1	101	100 2 No	3 Pro	bably 4 Unkno
S, F es that igned be del	by F	verted	" ecciney	Line	an w	gum				
Records, P ne law requires that e hes been signed b	De la	C	1 1	1 +	1		24e. Wes	en eutopsy	24b. W	ere autopsy findings
Cord  w require been si	Completed	ancer	of 1	well	1		perto	rmed?	CO	valiable prior to empletion of cause death?
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of Vital I Physicien: The this certificate	Be	25. Was case referred to medical axaminar?	lospital:		10	26. Place of Deat	h (Check only o	ne)		
Phys Phys	To	10 165 20 140	1 L Inpatient 2L	ER/Outpatien	I BUDOA	4 M Nursing Ho		lenca 6 □Ot		(y)
ding P. After	Certification:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe h	low injury occu	rred	
Division  or Attending after death.  Director: After din by the fune	cat	2 Accident investigation 3 Suicide 6 Could not ba			M 1	Yes 2 No				
ivi red red red red	E .	4 Homicide datarmined	28e. Placa of Injury - At h building, etc. (Speci	noma, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Num m, State)	ber or Rura	al Route Number,
DIVISION To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the										
Hospital 24 hours Funeral stely filled		29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	alcien: To the best of my knowner: On the basis of examina	owiedge, death	occurred at the t	ime, date and place,	end due to the	cause(s) end m	anner as s	iteted.
he H he Fi he Fi	edical	ane) 2 Medical Examin	and majorur sizes.	anon and/or in	resugation, in my	opinion, death occur	iou at the time, t	uate and placa	, and due to	Jule Cause(S)
To the within To the comple	2	29b. Signature and tipe of certifier	111		29c. Licen	se number		29d. Dete sign	ed (Month,	Dey, Year)
		A 11.	120		MD.	-23607	2	6 Or	+ 9	17
		117 119	/ 70			-1 - /				7

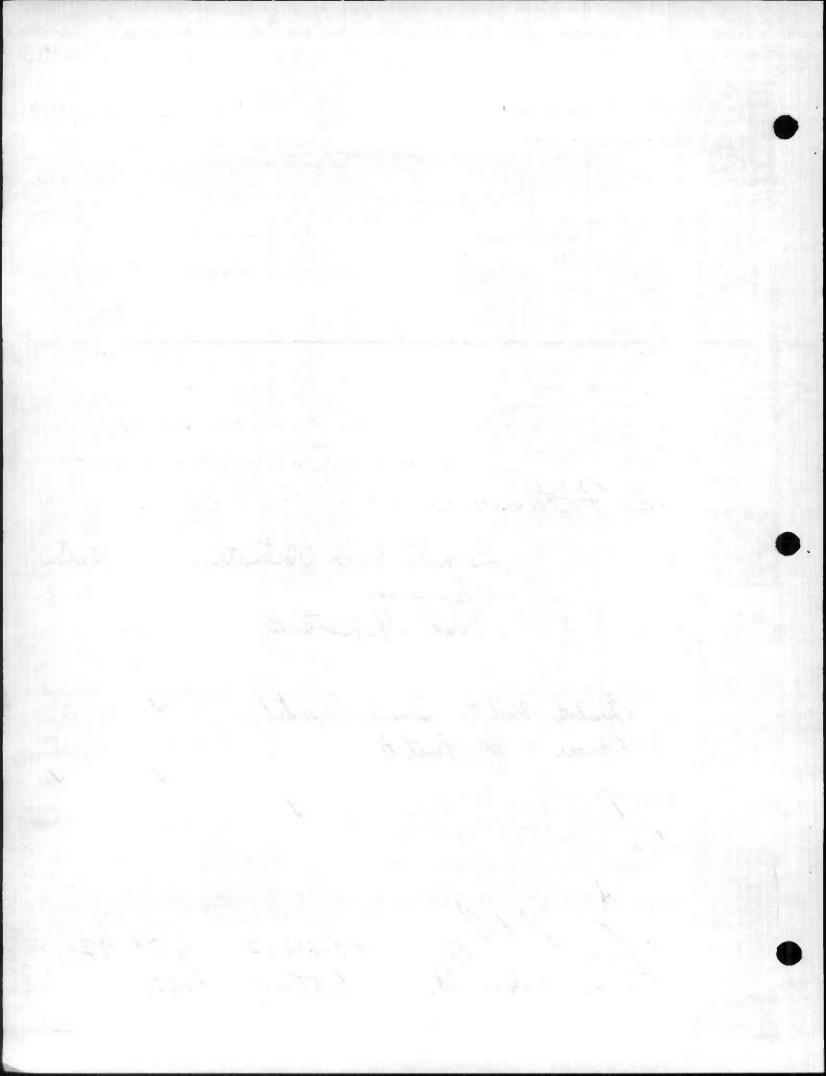
petrar's Signature Fisha Davidson-Randore

Boltimore 2/236

State

Registrar

OCT 1 0 1997



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 5 1997 4c. County of Death MARY GERTRUDE RYAN HEISLER October 8:50 AM 4e. Fecility Name (If not institution, giva street end number) 4b. City. Town, or Location of Deeth MANOR CARE, RUXTON NURSING HOME TOWSON If Under 1 Year If Under 24 Hrs. BALTIMORE COUNTY 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. lest birthday) Birthplece (State or Foreign Country) Deys Hours 1□ M 2□ F Yrs. 94 Dec 31, 1902 Pennsylvania 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Towson 10f. Zip Code 10g. Citizen of Whet Country? 21286 USA 14. Race - American Indien, Bleck, White, atc.

5. Sociel Security Number **Funeral** Director 139-30-4221 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Manyland neat of Heelth and Mental Hygiena. In the Manyland int: If term 27 is marked other than "natural", or items 23a or 23a-f show any or other traumatic event, the Medical Examiner matter notified at any or other traumatic event, the Medical Examiner matter notified at 10e. Stata Directo Maryland Baltimore County 10e. Street and Number 7925 York Road Funeral 11. Maritel Status 12. Wes Decedant Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 1 ☐ Never Merriad 2 X Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 21215-0020 1 ☐ Yes 21 No Specify: þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Special Education Teacher 4 Vrs Baltimore, Maryland 17. Fether's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middle, Melden Sumeme) Be ٩ Timothy Patrick Ryan 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mr. C. David Heisler, Son 20b. Place of Disposition (Name of commetery, cremetery, cremetery or other place)

15 Lochmoor Court, Lutherville, Maryland 21093
20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify) permit. Page Department of Important: If any Injury or Dulaney Valley Mem Grdns 10/8/97 Timonium, Maryland 21. Signature of Funeral Service Uceraee

Martin D. Lawson Mitchell-Wiedefeld Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Maryland 21212 Approximate shock, or heart failure. List only one cause on each line. Physician /Medicai Immediate Cause (Finel ASCUD disease or condition resulting in deeth) Examiner Due to (or es e consequence of):

Examiner Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest

**Physician** 

/Medical

**Examiner** 

Due to (or es e consequença of): Due to (or es a consequence of):

Specify: White

McLaughlin

29d. Date signed (Month, Dey, Year)

Onset and Death

Education

Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ Completed 24b. Wara autopsy findings eveileble prior to 24a. Wes an eutopsy performed? completion of cause of deeth? 1 ☐ Yas 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) 1 Yas 2 No Other: 

Nursing Homa 5 ☐ Rasidenca 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation Naturel 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Cartifying Phyaician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) end mennar steted. 29a. Certifier (Check only

29c. License number

-12-550

within 24 hours a To the Funeral D

The law requires that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vital or Attending Physician: burial-trensit

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certificate

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after deeth.

Hospital

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funeral director,

filled in by

31. Data filed (Month, Dey, Yeer)

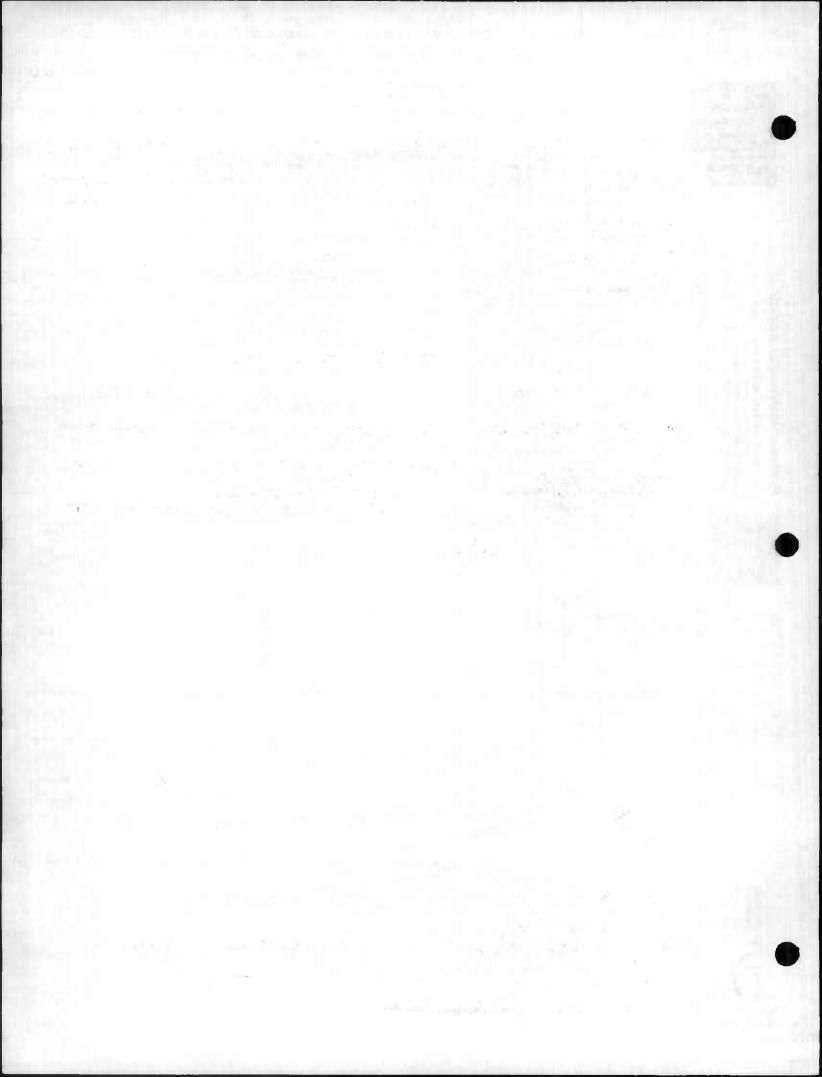
29b. Eignature and title of certifie

RD Tow son Registrac's Signeture

30. Name end/eddress of person who completed cause of deeth (Item 23e) (Type, Print)

XORK

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Daath 3. Tima of Death **Physician** Month Michael Richard Huffman UCTOBER /Medical 4e. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** Fallston General Hospital Harford Fallston | H Undar 1 Yaar | H Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | Sept 12, 1956 5. Social Security Number 6 Sex 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foraign Country) **Funeral** 1 M 2□ F Yrs. Director 41 218-68-6031 Mary land Usual Residanca of Decedant 10a Stata 10h County 10c. City, Town or Location 10d. Inside City Limits 25a-f show must be notified at Director 1 ☐ Yas 2 🗓 No Harford Street Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ŏ terns 23a 4028 Old Rocks road 21154 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - Amarican Indien, Black, Whita, atc. 1 ☐ Nevar Marriad 2 ☑ Married 8 1 Yes 2 No Spacify: by Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Dacedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) Mechanic 12 Small Engine Repair 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be 2 Floyd Wilson Huffman Alice Joy Bishop 19e. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Donna Huffman/Wife 4028 Old Rocks road, Street, MD 21154 altimore, rportant: If item 20b. Placa of Disposition (Nama of cematary, crematory or other pleca) 20e. Mathod of Disposition 20c. Location - City or Town, Stete Pages 1 ☐ Burial 2 M Cramation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation Carroll Crematory 10/9/97 Hampstead, Maryland 21. Signature of Funaral Service Unders 22. Nama and Address of Facility Lemmon Funeral Home 10 W. Padonia road, Timonium, MD 21093 23a. Part1 Enter the disease, or comprications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause in each line. Approximete Interval Batwean Onset and Deeth **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical ND-STAGE LIVER FAILURE

Due to (or as a consequence of): Examiner Examiner 1RONIC MONTHS Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaesa or Injury that initieted avants rasulting in daath) Last ettending physician end for use es the buriel-tra-Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 3 Probably 4 Unknown No þ Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings aveilable prior to complation of cause of death? certificete 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa raferred to medical axaminer? Be 26. Pleca of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) Hospital: ဥ 1 Inpatiant 1 Yas 2 ER/Outpatient 3 DOA 27. Menper of Death 28c. Injury et Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding invastigation 1 Yas 2 Accident efter death 6 Could not be datermined 3 Sulcida 28a. Place of Injury - At home, ferm, straat, factory, office building, atc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 D Homicide within 24 hours To the Funeral I completely filled edicai Cartifying Physician: To the bast of my knowledge, death occurred et the time, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, daeth occurred at the time, data and place, and due to the cause(s) and mannar stated. 29b. Signature end titla of certifiar 29c. License number 29d. Dete signed (Month, Day, Year) 0 30. Name and address of person who completed causa of daath (Itam 23a) (Type, Print) ALBERT S. C SUN, M.D 1800 HARFORD ROAD, FALLSTON, MD 21047 31. Data filed (Month, Dey, Year) 32. Registrar's Signature State 1 0 1997 Registrar

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State of Maryland / Department of Health and Mental Hygiene

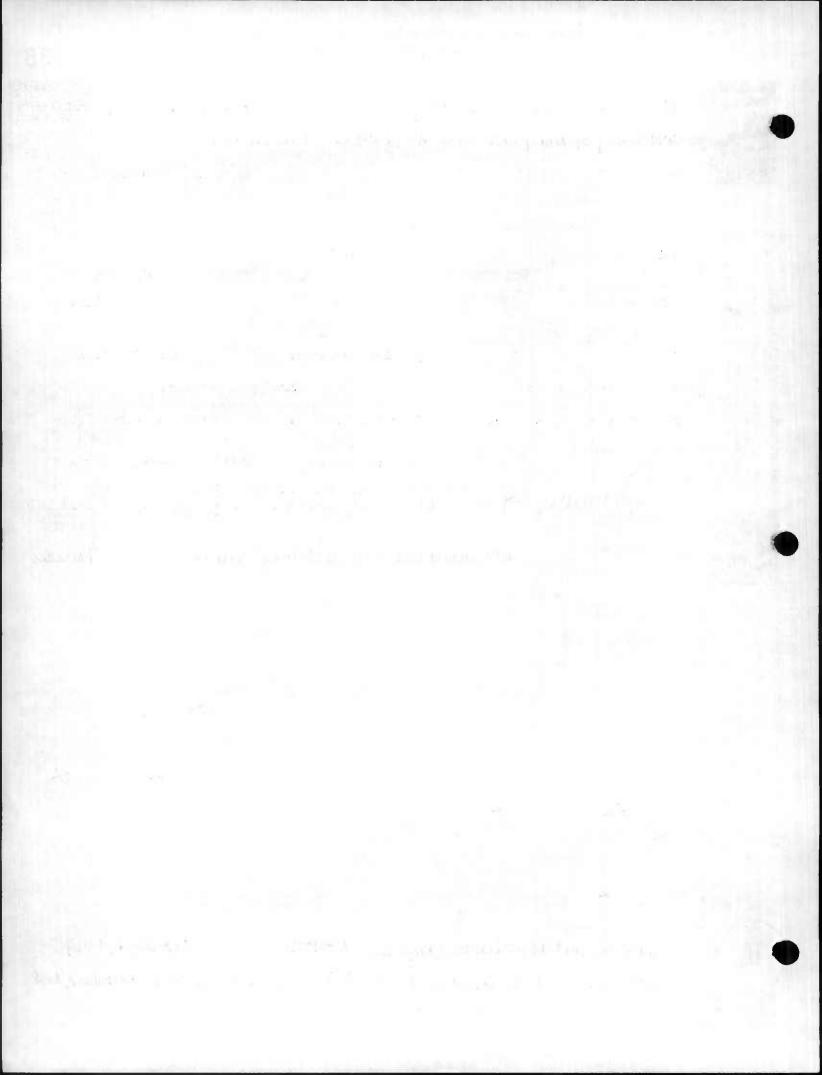
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Item 27 other tr		20a. Method of Disposition		comoto	of Disposition (Ne	eme of	ace)	Date	20c. Location	- City or Tov	vn, State
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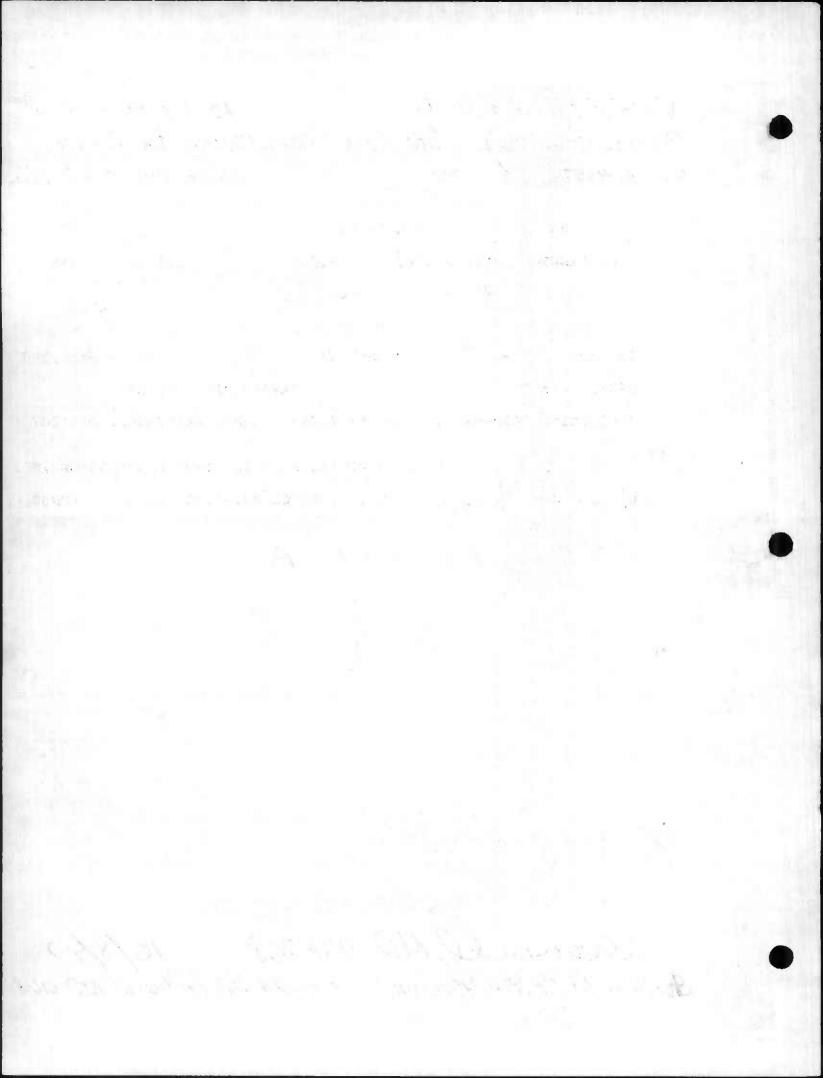
**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene

97 30739

		Certificate	of Death	P	leg. No.	
Physic		1. Decedant's Name (First, Middla, Last) VIRGINIAG, HAYWOOD		2. Data of Dea Month	th Day 1991	3. Time of Deeth
/Med Exami		4a. Facility Name (If not institution, give street and number)  Randall Stown Cenes Elder Care	4b. City, Town, or	Clstown	4c. County of Death	make.
Funeral Director		5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Undar 1	'aar If Under 24 Hr. ays Hours Mir	s. 8. Data of Birth	Year) 9. Birth	hpiaca (Stata or Foreign untry) YTh Calbliner
with the Maryland a or 28a-f show be notified at	tor	10e. Stete 10b. County 10c. City, Town or Location  MD na BALTIMORE.				10d. Insida City Limits 1
or 28	Director	10e. Street and Number 10f. Zip Co	de	1	log. Citizen of Whet Co	untry?
hours after death w tursh, or Hems 23s at Examiner must b	by Funeral		21229 of Hispanic Origin? (Cuben, Mexican, Pua	Specify Yes or No- rto Ricen, atc.)	14. Rece - Ame Bleck, White Specify:	
n 72 ho "nahun edical	Completed	15. Decedent's Education (Specify only highest grade completed)  (Give kind of work of the DO NOT use	ccupation lone during most of we etired)	orking	16b. Kind of Businass/	
d with	dwo	Collaga (1-4or 5+)			na -	disabled
office of the vent,	Be C	17. Fathar's Nama (First, Middla, Last)	T ***********	ama (First, Middla, I		GIGGOICO
Mant mrked attic e	To	JERRY FIELDS	FANN:	IE MAE	CALVER	
and 2 sthrall said said and a 27 is made of the said and a 27 is made of t		19e. Informent's Name/Reletionship (Type, Print)  JACQUELINE CARR-Daug.  19b. Melling Address (S			r, City or Town, State, 2 ALTIMORE, I	,
permit. Pages 1. Department of He frootstant: If Itam Tany Injury or oth		21. Signature of Funerel Service Licensee 22. Neme and A	r plece)	10-11-9		Town, State  LSTOWN, MD  AVENUE
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, a heart tellure. List only one cause on each line.				Approximate Interval Between
certificate be executed  rding physician and  use as the burial-transit	ne bunal-transit	disease or condition resulting in deeth)  Due to (or es a consequence of):  Due to (or as a consequence of):  b.  Due to (or as a consequence of):  if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initileted events resulting in deeth) Last  Due to (or es a consequence of):	¥ (			
- 53		Q				
by the	Physician	Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause	e given in Pert I.	23b. Did to		to the cause of death?
aw requires ts been sign 2 should be	Completed by			24e. Wes e	med?	Wara autopsy tindings available prior to completion of cause of death?
The page	Con			1 🗆 Y	es 2 No	1 □ Yas 2 □ No
Physician: The this certificate rai director, pag	Be c	25. Wes case reterred to medical axaminer?	Other:	eth (Check only or		
Attending Physic death.  ector: After this by the tuneral di	atlon: To	1 Inpatient 2 ER/Outpatient 3 DOA	Injury at Work? 1 Yes 2 No	1	ence 6 □Other (Spec ow injury occurred	cify)
or At efter d Direct in by	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, of building, etc. (Specify)	fice	28f. Location (St City or Town	treet and Number or Ru n, Stele)	iral Route Number,
24 hours 24 hours Funeral etely filled	edical	29a. Certifier  (Check only one)  1	na time, date end plac my opinion, deeth occ	e, and due to the curred at the time, d	ause(s) end manner es ete and piece, and due	stated. to the cause(s)
To the within 2 To the comple	Me		cense number	P 2	9d. Data signed (Month	Day, Year)
(6)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	+ POAS #	203 R	Attricas	MD 2128
Sta	100	31. Date filed (Morfth, Day, Year)  32. Registra's Signetura  OCT 101997  Auna Jandon Rondolf	12117 0	SIFI	11/10000	IND CICO



**Physician** /Medical Examiner

30740 3. Time of Death

YOYes 2□ No

00:15

**Funeral** Director

28a-f show

Director

Funeral

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Completed

Be

238 Herns 2

should be filed within 72 hours after and Mental Hygiene.

marked other than "natural", or ite. Baltimore, Maryland 21215-0020 Peges 1 and 2 should be f nent of Health end Mental ? pemil. Peges 1 and 2 sh Depertment of Health end Important: If Item 27 is m Iny Injury or other traum Ince. **Physician** 

/Medicai ⊨xamine

been signed the should be det this certificate Vital of After death. 24 hours To the Hosp within 24 hos To the Fune completely fi

ALKON

EDNA

Physician/Medical Examiner by Completed Be Medicai

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month HAMMOND MILES **EDNA** LOUISE 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death ST. AGNES HOSPITAL BALTIMORE | If Under 1 Year | If Under 24 Hrs. | S. Data of Birth (Month) Days | Hours | Min. | FEB 21, 1913 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 10 M 20 F MARYLAND 212-32-2430 Yrs. Usual Residence of Decedent 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2505 MAISEL STREET 21230 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 Nevar Marriad 2 Married 1 Yes 2 No Specify: Specify: AFRO AMERICAN ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK RESTAURANT 999- RESTAURANT 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) GEORGE MILES LENA MILES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) HAMMOND 3524 ROCKDALE CT, BALTIMORE, MARYLAND 21244 LESTER 20a. Method of Disposition 20b. Place of Disposition (Nema of cometery, cremetory or other place) 20c. Location - City or Town, State 1 Burlal 2 □ Cramation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BUSHY PARK CEMETERY 10/8/97 COOKSVILLE, MARYLAND ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 or complications that caused the eath. Do not anter the mode of dying, such as cardiac or respiratory arrest, let only one cause on each line. Immediate Cause (Final PULHONARY EMBOLISM disease or condition resulting in death) Due to (or as a consequence of): ESOPHAGEAL CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other algoriticant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Interval Betw

10min

26. Placa of Death (Check only one)

1 ☐ Yes 2 No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 6 Could not be determined

28b. Time of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

3 ☐ Suicide

4 Homicide

1x Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signatura and title of certifiar

29c. Licensa number

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MA

P. 10882

RUS VIOLETA, MD

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL; 900 CATON AVE; AGNES

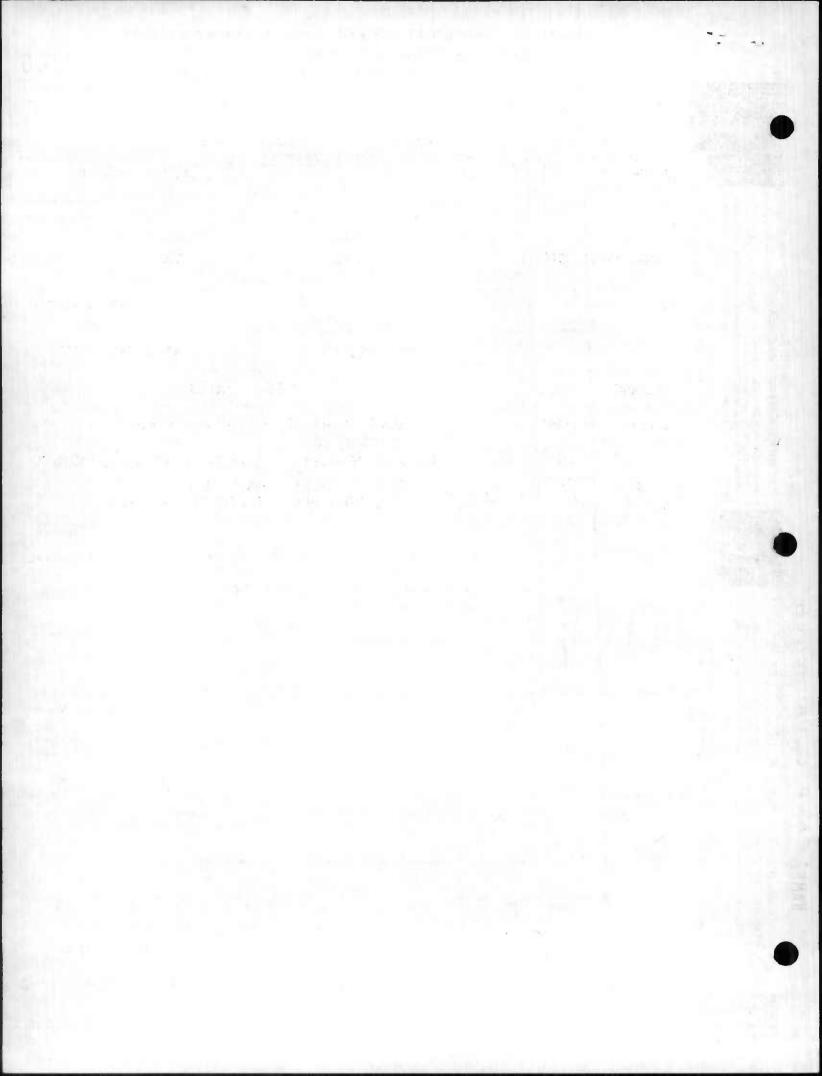
31. Date filed (Month, Day, Year) DCI

32. Registrar s Gignardie Jandare

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

Registrar



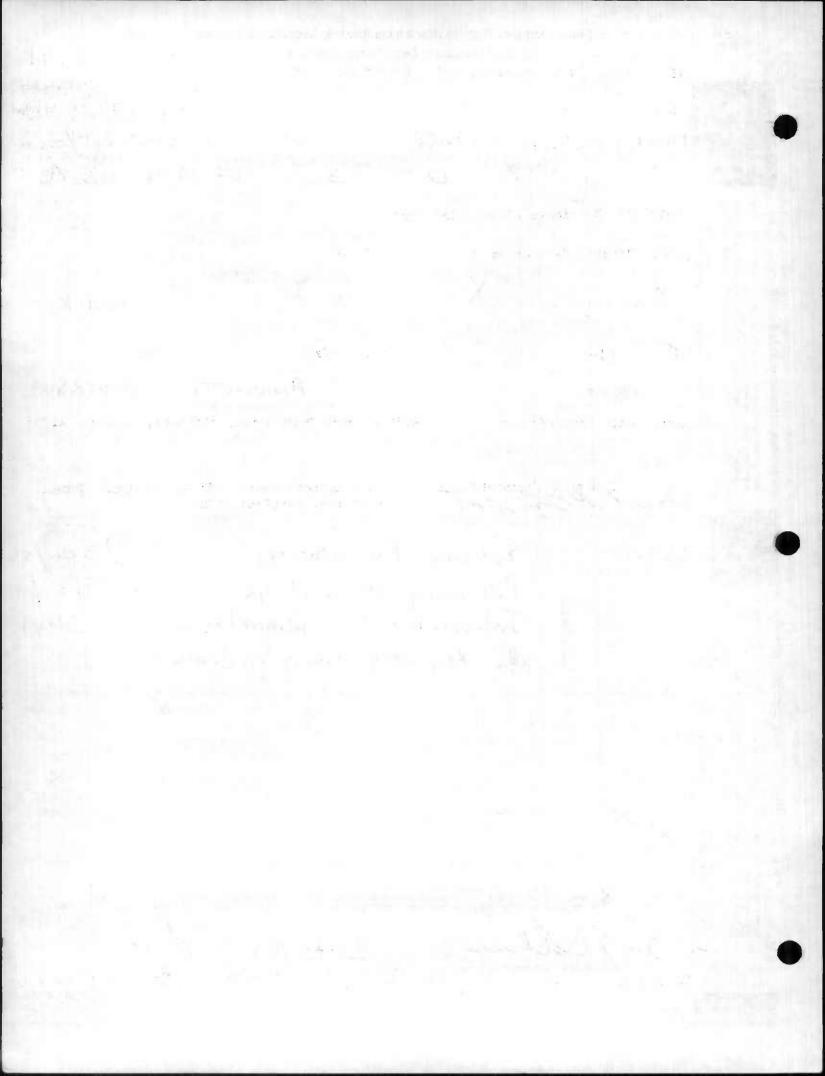
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

30741 Certificate of Death ITEM 24a perDR. G-752 10-10-97 eoh 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 01: 41 Am DAMIRA QUETTA 0 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL DAZTIMORE BINTO C If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day, If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Director Usuei Residence of Decedent 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28e-f shor the Medical Examiner must be notified at Baltimore City Maryland Baltimore 1 Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6052 Moravia Park drive 21206 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces 1 | Yes 2 D No If Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No p Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within and Mantal Hygiene. al Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) none-infant none 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked ANTOINETTE ROGERS Lo unknown 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If hen 27 is or any injury or other traun once. Antoinette Rogers/mother 6052 Moravia Park Drive, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removei from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee

Joseph B VanSant 22. Name and Address of Fecility State Anatomy Board, 655 W. Baltimroe Street Baltimroe, Maryland 21201 23a Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervei Between Onset end Death Physician Prematuri /Medical Immediate Cause (Final disease or condition Examiner Due to (or as a consequ monary Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last **burlai-tran** pue Due to (or es e consequence of) physician street the burial aventric Box 68760 Physician/Medical Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yss 2 No 3 Probably 4 Unknown á 2 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? **Dage 2** 1 Yes 2 No 2046 certificate 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospitali Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 25 No 2 ER/Outpatient 3 DOA 쿭 27. Manuel of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Ather 5 Pending death. 1 Yes 2 No investigation 2 Accident or Attend after deat Director: 3 ☐ Suicide □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

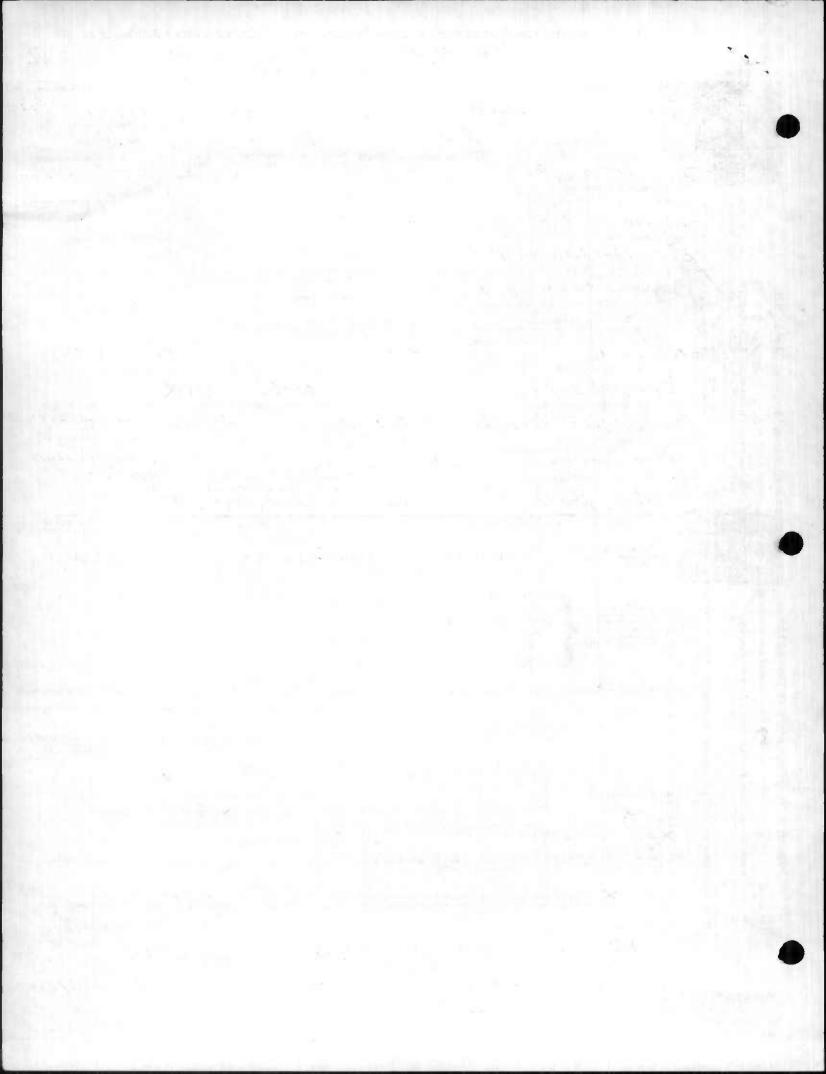
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29b. Signiture and title # cer 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mercy Medical Center, 301 STPAUL PLACE; BAITMIRE Md 2/202 Susan J. Duckerian, M. D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95



30742

•					Certific	ate of i	Death		Reg. No.		
Physic	ian	1. Decedent's Name (First, Middle, La		. 11-		3300		2. Dete of D Month		Yeer	3. Time of Death
/Medi		JAMES NA		TE	NRO			Oct.	7	1997	120 PM
Exami	ner	4e. Fecility Nama (If not institution, given 5609 NARC	re street end number)	AU3		4	Bolti		th 4c. County	of Deeth	?
Funeral Director			Sex 7. Aga	(In yrs. last birth	mday) If Ur Mont	hs Days	If Undar 24 Hrs Hours Min		ey, Yeer) 1930	9. Birthpie Country JAH	ce (Stata or Foreign y) AICA, W.I
fand M M		10a. State 10b. County		10c. City, Town	or Location					100	d. Inside City Limits
th with the Maryla 23s or 28s-f shorust, be notified at	Director	Haylow ~	10	3		HORE			40.000		1 Yes 2 No
23a or	ral Dir	5609 NARCIS	sus Aus	7	101.	Zip Coda	1/5		10g. Citizen of	7 LAN	•
na . or items	by Fune	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evaluation Armed Forcas?  1 Yes 2 Not lif Yes, Give Yeer or Datas:		if Yas, s	ecedent of H specify Cube s 2 2 No	ispenic Origin? (5 n, Mexican, Puel Specify:	Specify Yes or N to Rican, atc.)		ce - Amarican ck, Whita, at	
(F. 18)	bete	15. Decedent's E (Specify only highest gra	ducation ada completed)	16e. I	Decedent's U	suei Occup	etion during most of wa	rkina	16b. Kind of B	usiness/Indu	stry
MA	Comp	Fl-manta- (C	College (1-4or 5+		life. DO NO		during most of wo		TURNE	BULL	35/28
Y	Be.C	17. Fathars Neme (First, Middle, Last					18. Mother's Na	ma (First, Middle	, Meiden Sumen	ne)	
Ment Ment prrks	0	ERIC HEN	RY				Mas/ E		INK		
d 2 should th and Mei 7 Is marks traumatic	m	19a. Informent's Neme/Reletionship (	Type, Print)	19b.	-				per, City or Town,		,
f Health fam 27 other tr		GUENDULYN E.	HENRY /W	1/2 56			ssur Au				2/2/5-
8 7 2		20e. Method of Disposition  1	Removal from Stete		, cremetory	or other plec	e)	Dete	BIRMING		
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeref Servica Licer	nsae	<u>Jornan</u>	10040	RUSI	UKI / E/ CUIL	1 , 6 000		rist	H.
		23e. Pert. Enter the disease, or com	plications thet caused t	he death. Do no	ot enter the r	node of dyin	g, such es cardie	c or respiretory	2/2/5-		Approximete
Physician		ehock, or heert feilure. List only	one ceuse on eech ilne	).						ir	ntervei Between Onset and Deeth
/Medical	9	Immediate Ceuse (Finel disease or condition	Moto	static	Ca	lan	Canc	-			2 years
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ficate be a physician is the buni	edicai	fried fulfiglied events	c	ue to (or es e co	nsequance o	of):					
ding ding	ξ	resulting in deeth) Last	d							1	
a attend	icia	Pert fl. Other significant conditions of	ontributing to death but	not regulting to	the underlyin	a course shu	on in Part I	och Die	tohenno use no	ntelbute to t	he cause of death?
at the de i by tha s etached	Physician	7 or ii. Other significant conditions o	onthouting to death but	not resulting in	the underlyin	ig causa give	in in Fait I.		Yes 2 No		bly 4 Unknown
as that igned b	by									T	
law requiras that the death as been signed by tha atter a 2 should be detached for u	Completed							24e. We	s an autopsy ormed?	avelle	e autopsy findings ebie prior to pletion of cause eth?
a - 0	Com							10	Yes 2 No		Yes 2□No
ysician: The secretificate director, pag	Be (	25. Wes case referred to medical exeminer?					26. Plece of De	eth (Check only	one)		
Physician: r this certific aral director,	10	1 Yes 2 No		2 ER/Out	patient 3	DOA Othe	er: 4 Nursing I	loma 5 Res	idenca 6 DOth	er (Specify)	
l or Attending Ph aftar death. Director: After th		27. Mennar of Death  1. Neturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of injury (Month, Dey	Year) 28b. Ti	me of ury M	28c. Injury Work	ret k? Yes 2 □ No	28d. Describe	how Injury occur	red	
or Attending after death. Director: After d in by the fune	Certification:	3 Suicida 6 Could not be determined	28a. Placa of fnjur building, etc.	y - At homa, fam (Specify)	n, street, fec	tory, office		28f. Location City or To	(Street and Numb wn, State)	per or Rural F	Route Number,
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	edicai C	29e. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of niner: On the basis of e	xaminetion end	death occurr or investiget	ed et the timi ion, in my op	e, dete end plec pinion, deeth occ	a, end dua to the urred et the time	causa(s) and ma , date end piece,	annar as stat end due to th	ed. ne cause(s)
o the	Me	29b. Signeture and title of certifier	and mainer state			29c. Licanse	number		29d. Dete signe	d (Month, De	y, Year)
- × - ö		onn.				Die	1501				
/1		30. Neme end eddress of person who	completed cause of dee	oth (Item 23e) /T	voe, Print)	114	1561		10/8/	7/	
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Sta	te	31. Date filed (Month, Day, Year)	32. Registrer	's Signeture	15.0	4.1.		-1.7> 1	11/1/11/		-111/

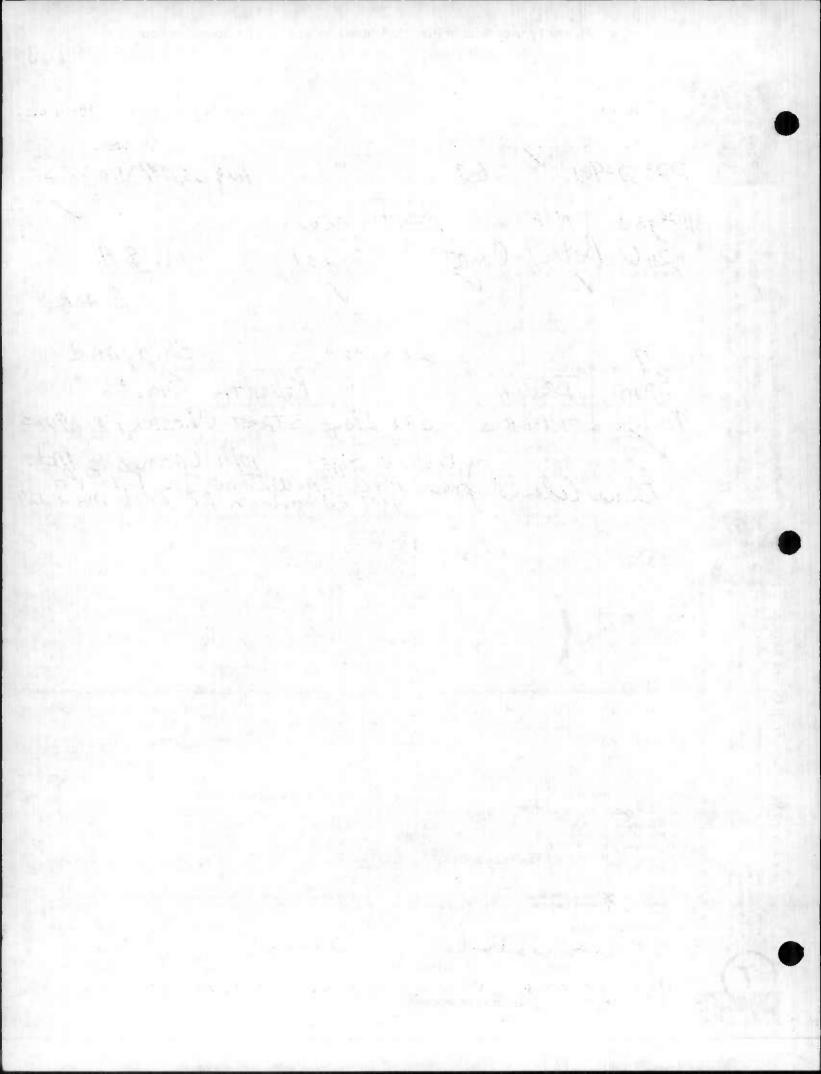


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Deeth Day **Physician** JUNIOR IRVIN October 6, 1997 /Medical 10:10 a.m. 4a. Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** STELLA MARIS HOSPICE TOWSON
if Under 24 Hrs.
Hours Min. Baltimore if Under 1 Yeer Age (In yrs. last birthday) **Funeral**  Birthplece (Steta or Foreign Country) 22350 Months Days -901 Yrs. Director Usuai Rasidanca of Dacedant Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mentel Hygiene. 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Examiner must be notified at Director 1 PYas 2 No 288-11 10e. Streat and Number 10f. Zip Coda 10g. Citizan of What Country? 23a or 2 Funerai Was Decedant of Hispanic Orlgin? (Spacify Yas or No-if Yas, specify Cuben, Maxican, Puarto Rican, atc.) Race - American Indian. Was Decedant Armed Forces? Bleck, Whita, atc 1 ☐ Yes 2 ☐ If Yas, Give Year or Datas: 1 Navar Married 2 Merried 2 No Baltimore, Maryland 21215-0020 "natural", or 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed th and Mantel Hygiane.
7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highast grada complated) Decedant's Usuei Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) DORE 17. Fethar's Nema (First, Middla, Last) nar's Name (First, Middla, Maidan Su Be 0 Dober 19a. Infor Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or nt of Health e : If Item 27 is or other trac 532 20b. Placa of Disposition (Name of cometery, cramatory or other of Disposition Data 1 Deurial 2 Cremetion 3 F 4 Donation 5 Other (Specify) place 3 Ramoval from State **Department** important: It any injury o 21. Sign of Funaral Sarvice Licen Ed mondson 23e. Part1. Entar tha diseesa, or complications that caused the death. Do not a shock, or haart feilura. List only ona causa on agch line. ac or raspiretory errest, Approximate Interval Batween Onsat and Deeth **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in deeth) Examiner Due to Physician/Medical Examiner Attending Physician: The law requires that the deeth certificate be executed the bunel-transit Sequentially list conditions, if any, laading to immadiate causa. Enter Undarlying Cause (Disaesa or injury that initieted evants rasulting in death) Last Division of Vital Records, P.O. Box 68760, Dua to (or es e consequance of): USB BS cate has been signed by the e page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Onknown Be Completed by 24b. Wera autopsy findings available prior to complation of causa of daeth? 24a. Was an autopsy performed? After this certificate 1 Yas 2 No director, 25. Was casa refarred to medical 26. Place of Deeth (Check only ona) 2 Other: 4 Nursing Homa 5 Residence 6 MOthar (Specify) HOSPICE 1 ☐ Yas 2 ☐ No 1 Inpatiant 2 ER/Outpatient 3 DOA eral Director: After thi filled in by the funeral 27. Mannar of Death Deta of injury (Month, Day Year) Medical Certification: 28b. Tima of 28d. Dascribe how injury occurred 28c. injury at Work? Naturei 5 Panding invastigation 1 Yas 2 No death 2 Accidant 3 Suicida 6 Could not be determined 28a. Pieca of Injury - At homa, farm, straat, fectory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 4 Homicide 8 Hospital C To the Hospital within 24 hours e To the Funeral C 29a. Cartifian 💹 Certifying Phyalcian: To the bast of my knowledge, daeth occurred at the tima, data and pieca, and dua to tha causa(s) and mennar as stated. Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end mennar stated. 29b. Signeture 29c. Licensa number 29d. Data signed (Month, Day, Year) 30. Name and addrass of person who completed causa of daath (Itam 23a) (Type, Print) PENELOPE EDWARDS 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificate	or	Death			Reg. No.			
Physiclan	_	<ol> <li>Decedant's Name (First, Middla, Last,</li> </ol>	)							2. Data of De Month_		Year		me of Death
/Medical	ı.		N			JOH	-		_	OCTOBE		1997	4:	30 PM
Examiner	1	te. Fecility Name (If not institution, give Saint Joseph M			er				WSO	ocation of Deal		ty of Death Balt i	moı	^e
Funeral Director	1	5. Social Sacurity Number 6. Sa:  213289046  Usual Residence of Decedent	M 20F	7. Age (In yrs. 69	last birthday) Yrs.	If Under Months	Yaar Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D	rth ay, Year) O 1928	9. Birthp Coun NAA	itry)	tate or Foraig
72 hours efter death with the Maryland netural; or items 23s or 28s-f show digal Examiner must be notified at each by Funeral Director	-	10a. State 10b. County		10c. City	y, Town or Lo	ocation						1	0d. Insi	de City Limits
vith the Maryla or 28a-f show to not like at Director	1	JARYLAND HARFOR	20	F	OREST	THIL					40.00			Yes 200 No
23a or		10e. Street and Number  262 A. Rocks	Ros	0		10f. Zip	210	150			10g. Citizan o	Vinat Coun	itry /	
er, or items 23s or Examiner must be by Funeral Di			Armed Fo	2 No	_		nt of I		in? (Spi Puerto	ecify Yes or N Ricen, etc.)	o- 14. Ra Bl	ace - Amaric ack, White,		an,
"natural".		15. Decedent's Edu	cetion	ates: KoR	16a. Dece	dent's Usua	Occup	pation			16b. Kind of	Business/Inc	dustry	5
then the Man		(Specify only highest grade	College (1	-4or 5+)	(Give	DO NOT US	done retire	during most	of work	ing	GALTI GAS+			c Lo.
		17. Father's Name (First, Middla, Last)	-110	0 - 2				18. Mother	's Name	e (First, Middle	Maidan Suma	ima)		
To		19a. Informant's Name/Relationship (Ty		SON	19b. Maili	ng Address	(Street	and Number	or Run	al Route Numb	Der, City or Tow	n, State, Zip	Code)	21050
2	2	ROBERT L. PULLED 20a. Method of Disposition	SR.		abak lace of Dispo	osition (Nam	e of	ROAK	OF	Date	Hill S 20c. Location	TARY - City or To	LA own, Sta	nte C
ury or		↑ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		State	RKW	2000	zn	SIERY		1665,	PARK	اعلات	MA	RYLAN
any injury or othe once.	1	21. Signature of Funeral Service License	ie l		5	2. Name and	Addre	SS of Facility	970	BURG	R, RF	1. '		2105
clan		23a. Part1. Enter the disaase, or compli shock, or heart failure. List only or	catio s that cone cause on e	aused the death ach line.		ter the mode			Riv	2 For respiretory	Perrest,	LIT L	tnterva	XLACO kimete Il Between and Death
lical Iner	I	Immediate Cause (Final disease or condition resulting in death)		Due to (o	RTHYM							1		
ial-transit Examiner		_ t	STAT	US POS	ST CO	RONAF	Υ	ARTER	YE	SYPASS	GRAFT			
		Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last	ARTH	HERIOS(	CLERO as a consec	TIC H	ΙEΑ	RT DI	SEF	ASE		1		
JSB 68		Costumy in Goath, East	l									1		
ached	Ī	Part II. Other significant conditions con	tributing to de	eath but not resu	ulting In the u	nderlying ce	use giv	en in Part I.			tobacco use c			use of death
2 2	1	ABDOMINAL AORT	C ANI	EURYSM		_					1148 20140	3   1100	DEUTY	+ LAOIIKIIO
page 2 should	-	POST OPERATIVE	ILEUS	5							s an autopsy ormed?	col	ailable p	psy findings prior to n of ceuse
certificate he rector, page					. <u>.                                   </u>					150	Yes 2□No	X	Yes	2 No
		25. Was cese referred to medicel examiner?  1 □ Yes 🐒 No	ospitel:	npatient 2	ER/Outpatier	nt 3 DO	Oth	or.		h (Check only	one) idence 8 🗆 O	ther (Specif	v)	
		27. Manner of Death  1 Natural 5 Pending  2 Accident investigation		of Injury th, Day Year)	28b. Time o Injury		c. Injui Wo				how Injury occi		,,	
in by		3 Suicide 6 Could not be determined	28e. Piace buildin	of Injury - At hong, etc. (Specify	ome, ferm, sto	eet, factory,	office				(Street and Num own, State)	nber or Aura	il Route	Number,
Fune tely fil		29a. Certifier (Check only one)  **Certifying Physics** 2   Medical Examination**	er: On the ba	best of my knownsis of exa <i>m</i> inat ner stated.	wledge, deet ion and/or In	n occurred a vestigation,	t the tir	me, date and opinion, death	place, h occurr	and due to the ed at the time	cause(s) and r , date and place	manner as st e, and due to	tated.	use(s)
To the comple		29b. Signature and troubt partitier	2.4	fe,	MD	29c.		543			29d. Date sign	ad (Month,		
)	3	30. Name and address of person who co					D T	OWSON	٧, ١	MARYLA	AND 21			

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	Physic	ian	D 1 1 1		T	0. 1/			Month	Day	1997	10155 AT
1	/Medi		4a. Facility Nama (If not institution,	Lizabeth		enkin		. City, Town, or Lo	oction of Death		1 1	10.33 M
	Exami	ner	4a. Facility Nama (II not institution,			S. Green	5t, 40.	7		4c, Coun	ty of Death	
ш	-	_	5. Social Security Number	of HD. Me	dicul	Center	der 1 Year	If Under 24 Hrs.	nore		0.00	t (Co.)
н	Funeral		116-48-0726	6. Sex 7. A	ga (In yrs. last	Yrs. Mont		Hours Min.	8. Data of Birtl (Month, Day	Y, Year)	9. Birthp	placa (State or Foreign
	Director		Usual Rasidence of Decedent		71				Sept. 2	11956	Wash	ington Di
	wo w		10a. Stata 10b. County		10c. City, T	own or Location	-				1	0d. Insida City Limits
	Mary	ō	Hd. BALT	more	Ray	ndalls	towar	`				1 Yes 2 No
	72 hours after death with the Maryland natural, or items 23s or 28s-f show dical Examiner must be notified at	Funeral Director	10e. Street and Number	111101	1100		Zip Coda	)		10g. Citizen of	What Coun	itry?
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	Pa 2	era	11. Marital Status		t Evar in U.S.	13. Was De			ecity Yes or No-	14. Ra	ce - Americ	an indian.
	ther of the control o	Fur	1 Nevar Married 2 Marrie	12. Was Decedent Armed Forcas d 1 ☐ Yes 2 ☑	No			panic Orlgin? (Sp , Maxican, Puarto	Rican, atc.)	Bi	ack, White,	etc.
320	ars a		3 ☐ Widowad 4 ☐ Divorced	if Yas, Giva Year or Dates:		1 🗆 Yas	2 2 No	Specify:		Spec	MY: RI	ACY
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21	filed within Hygiene.	E	12	Collaga (1-40)	F	ood Sen	nce A	Hendo	int	Res	turo	int
	Hygie other	BeC	17. Father's Name (First, Middla, L	ast)			1	8. Mother's Nam	a (First, Middla,	Maldan Surna	ma)	
a	should be filed of Mental Hygi marked other matic event,	To	Bernard L	amont	Jen	KINS		Josep	phine	OL	ve	Cheek
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e,	of He item		20a. Mathod of Disposition		20b. Plac	a of Disposition (	Vama of		Data	20c. Location		
Ĕ			1 Burial 2 □ Cramation 4 □ Donation 5 □ Othar (Sp		9 0		Hemor	1 00	oct. 11,97	R	altu	mare
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m	Depariment of the same of the		KY	1)	Trans	Ra	hald A	Grays	on Fu	neral	Ser	vice
	NAME OF		23a. Part1. Entar the disaase, or o shock, or haart failura. List o	omplications that causa	nd tha daath. I	Do not enter tha	node of dying,	such as cardiec	or respiretory er	rest,	1-0,000	Approximate Interval Between
1	Physician										}	Onset and Death
4	/filedical Examiner		Immediata Causa (Final disease or condition		Seps	15						7days
1	Examined		resulting In death)	a	Dua to (or as	a consequence	of):					
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	and trans	Examiner	Sequentially list conditions,			a consequence					T	
30,	ata be axecuted hysician and the burial-transit	E	Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disaasa or Injury	CV	A						1	H days
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Box	law requires that tha death certificata be assecuted ass been signed by the attending physician and a 2 should be datached for usa as the burial-transit	Physician/M										
	the s	ysic	Part II. Other significant condition	s contributing to death I	but not rasultin	g in tha underlyin	g causa given	in Part I.	23b. Dld t	obacco use o	ontribute to	the cause of death'
P.0	hat the								10	Yee 2 No	3 Prol	bably 4 Unknow
Records,	signed dated	l by							24. 144.	93.500-00C	24h 146	are autonou findings
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2	ding P. After t	:uo	27. Mennar of Death  1 ☑Naturel 5 ☐ Panding	28a. Data of Inj (Month, D	ey Year) 28	b. Tlma of injury	28c. injury a Work?		28d. Describe it	now injury occ	urred	
Sio	Attending or death.  ector: After by the fune	cati	2 Accidant Investig			M.	1 🗆 Ya	as 2 No				
Division	for Attendi	Certification:	4 Homicida detarmin	ad 289. Placa of it	njury - At homa itc. <i>(Spacify)</i>	, farm, street, fed	tory, office		28f. Location (S City or Tow	Straat and Nur vn, State)	nber or Rura	al Routa Number,
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	To the Hospital within 24 hours of To the Funeral I completely filled	edicai	29a, Certifiar (Check only one) 2 Madical E	Physician: To the best karniner: On the basis of	of axamination	and/or Invastigat	ed at tha tima ion, in <i>m</i> y opir	, data and placa, nion, daeth occur	and dua to tha cred et the time, c	causa(s) and r data and place	nannar as si o, and due to	tated. the causa(s)
	the thin the mple	Mec	29b. Signatura and titla of certifiar	and mannar s	idlet.		29c. Licansa	number		29d. Data sign	ed (Month	Day, Year)
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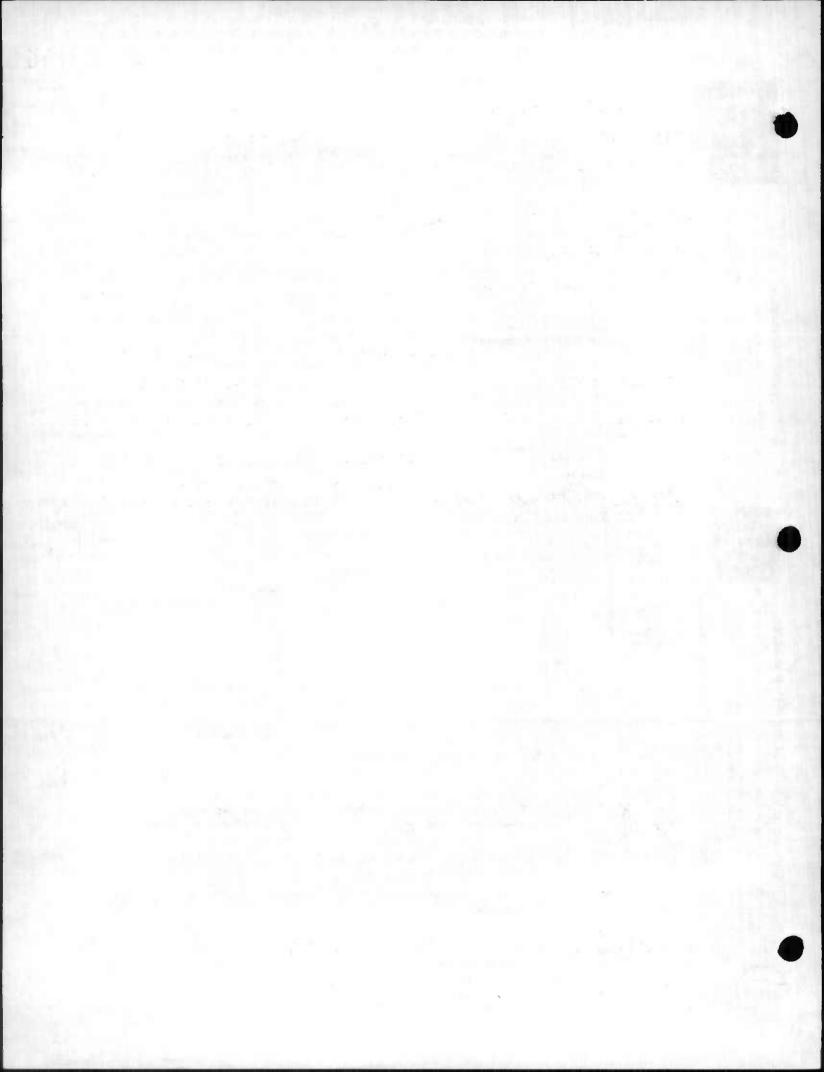
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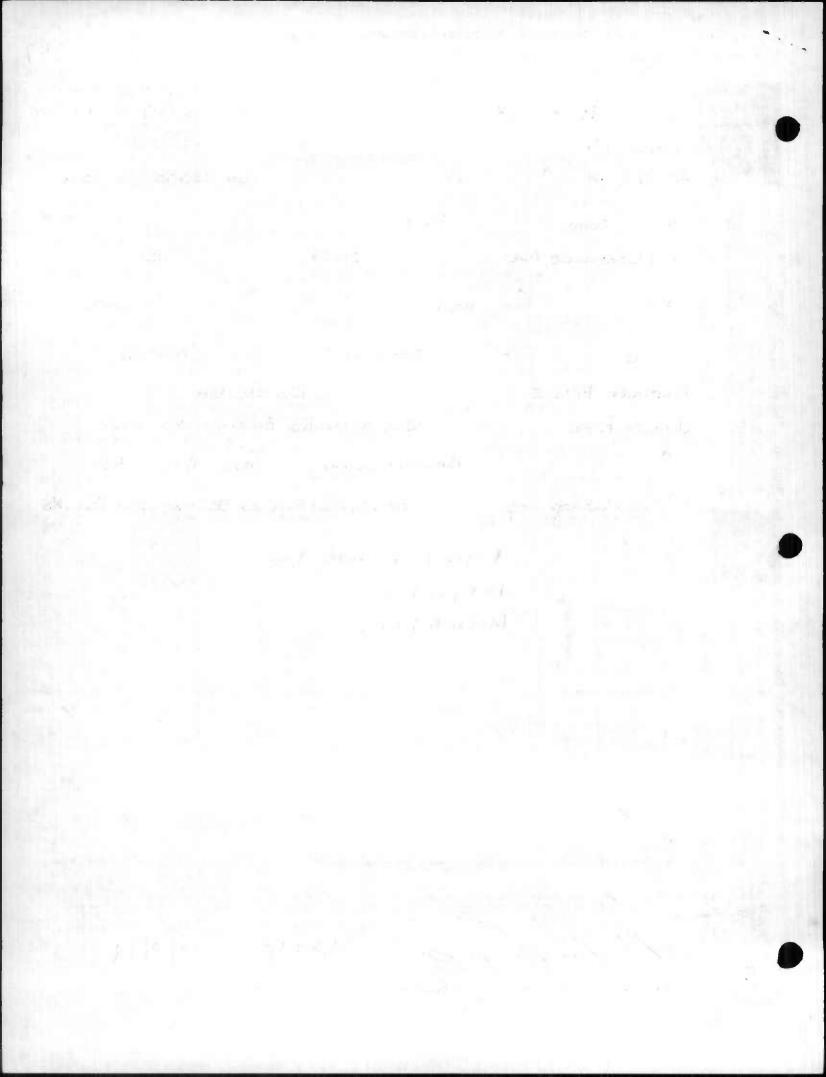
						Certificate	e of	Death		Reg. No.	01	30/46
	Dhysia	on.	1. Decedent's Name (First, Middle, Las					11-91	2. Dete of D Month	Day	Year	3. Time of Death
	Physic /Medi		JAMES S.						OCTOB	ER 10,	1997	1:30PM
	Exami	ner	4a. Facility Neme (If not institution, give 2110 CAMBRIDGE					4b. City, Town, or I		th 4c. Count	y of Death	
	Funeral Director		Social Security Number     6. Security Number		In yrs. last bii 81	thday) If Under Yrs. Months	1 Year Days	If Under 24 Hrs.		ay, Year)	9 Birthola	ce (State or Foreign
	D		Usuel Residence of Decedent						1		111111	LAND
	show	2	10a. State 10b. County			n or Location					100	d. fnside City Limits 1. Yes 2 □ No
	28a-f	Director	MARYLAND N	/A	BALI	IMORE 10f. Zip	Code			10g. Citizen of	What Countr	<b>\</b>
	death with the Maryland ms 23s or 28s-f show	al Di	2110 CAMBRIDGE	STREET				231		USA		
020	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health end Mental Hygiene. I them 27 is merked other than "natural", or items 23e or 28e-f show then traumatic event, the Medical Examinar must be inclified at	by Funeral	11. Marital Status  1 Never Merrled 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	er In U,S.	13. Was Deced If Yes, spec		Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	o- 14. Ra Bla Speci	ca - American ack, White, et fy: WHI	c.
2-0	72 hou		15. Decedent's Ed	ucation	16a	Decedent's Usua	l Occup	pation during most of work	kina	16b. Kind of E	Business/Indu	stry
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Q 7	Hygier th	CO	6 YEARS  17. Father's Name (First, Middle, Last)		ER	ECTOR/S	HI	P YARD  18. Mother's Nan	ne (First Middle	BETH :		_
an	id be ental ked o	To Be	STANLEY KNOZEK						,	AWORSK		
Maryland	2 should be end Mental Is marked of aumatic ev	-	19e. Informent's Name/Relationship (7	ype, Print)	19t	. Mailing Address	(Street	t and Number or Ru	ral Route Num	ber, City or Town	, State, Zip C	ode)
	and and a m 27 I		MRS. ELIZABETH					IDGE STR		ALTO. 1		1231
>	t. Pege ment of tlant: If		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemete	f Disposition (Nam ry, crematory or of TANISLA	ther pla	-	Dete 10-13	BALTO		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Ceuse (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	b. Seps	S e to (or as a	not enter the mode	JUNI a of dyi	DALK AVE	NUT B	ALTO.	1	1222 Approximate niterval Between Onset end Deeth
Box 68760	5 0 0	Medical	cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	C. Due	e to (or as e	consequence of):						
O.	the att	Physician/	Pert II. Other significant conditions co	ntributing to death but n	ot resulting l	n the underlying ca	ause gi	ven in Pert I.	23b. Die	tobacco use co	ontributa to t	he cause of death?
P. 0	that the								1	Yes 200	3 Probe	ibfy 4 ☐ Unknown
Division of Vital Records,	aw requires that the death cer is been signed by the attendir 2 should be detached for use	Completed by							24a. Wa	s an autopsy ormed?	avail	e autopsy findings lable prior to pletion of cause eath?
E E		Com							1□	Yes 2 No	10	Yes 20 No
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0	E E	: To	1 ☐ Yes 22 No 27. Manner of Death	1 ☐ Inpatient	2 ☐ ER/Ou		A	her: 4□ Nursing H rv at		how injury occu		
sion	or Attending Physician: after death. Director: After this certific. I in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day Ye	ear) I	М		rk?  Yes 2□No				
DIV	を共元日	Certif	4 Homicide determined	28e. Placa of Injury building, etc. (\$	- At home, fa Specify)	rm, atreet, factory,	, offica			(Street and Num own, State)	Der or Hurai I	route Number,
	To the rospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or the funeral	edical	29a. Certifier (Check only one)	raicfan: To the best of m iner: On the basis of exa and manner stated	amination an	, death occurred a d/or investigation,	t the ti	me, dete end place opinion, death occu	, end due to the rred at the time	cause(s) end m	anner as stel , and dua to t	led. he cause(a)
	To the	Me	29b. Signeture end title of certifier	1 ,		29c.	Licens	se number		29d. Date sign	ed (Month, Da	ay, Year)
			Stephanie	Linder	MI	1	14:	3909		October	10, 19	97
			30. Name and address of person who c	1 / 1			7,	2211				
	Sta	te	31. Date filed (Month, Day, Year)	Ve Balti	more Signature		d/	224				
	Registr		OCT 1 0 1997	32. Jegistreis	widson-i	fandell						



State of Maryland / Department of Health and Mental Hygiene

30747

						Cei	rtificate d	of Death		F	leg. No.			
		1. Decedent's Neme	(First, Middle, La	ist)						2. Data of Dea	th	Vac-	3. Time of De	eth
Physic /Medi		William	H. V	(RAUSE						Month CCT	Day 199"	Yaar	1040	M
Exami		4a. Facility Name (If r			ber)			4b. City, To	wn, or Loc	cation of Death		ty of Death		
		STELLA	MARIS					Tou	150m		Bo	uto.		
uneral		5. Social Security Nur	nber 6. S	Sex 7	. Aga (In yrs.	last birthday)	If Under 1 Ye	ar If Under	24 Hrs.	8. Date of Birth	1	-	lece (Stete or F	oreign
irector		213-09-80 Usuel Residence of D	224	1 <b>Ø</b> M 2□ F	79	Yrs.	Months Da	ys Hours	Min.	Month, Dey	3,1918		yland	
M III		10a. State	0b. County		10c. Cit	, Town or Lo	cation					1	0d. Inside City I	
E P	Director	MD.	Balto.		F	arkvill	e						1 🗆 Yes 2	Ŏ No
Or 20	Dire	10e. Street and Numb					10f. Zip Coo				10g. Citizen of	What Coun	try?	
23		2427 Lav	CEWOOT	Ave			212	134			US	A		
F. I	Funeral	11. Marital Status		12. Was Deced Armed Ford	ant Evar in U, es?	S. 13. \	Was Decedent f Yas, specify C	of Hispanic Or Suban, Mexica	lgin? (Spe n, Puerto F	cify Yas or No- Rican, etc.)	14. Re BI	ce - Amaric ack, Whita,		
al', or items 23s or 28s-f show Examiner must be notified at	by	1 Never Married 3 Widowed 4		1 🗷 Yes 2 If Yes, Give Year or Dat	es: WWI		1□Yes 2 🗖				Spec			
"natural", edical Exz	Completed	(Specify	5. Decedent's En	ducetion		16a. Deced	dent's Usual Oc	cupation	at of working	20	16b. Kind of	Business/Ind	dustry	
- 36	nple	Elementery/Second		College (1-4	lor 5+)		kind of work do DO NOT use re	tired)		.8				
other than	CO	12		+		TYPE	SETTER				PRINT			
d othe	Be	17. Father's Name (Fi	1.7	)						(First, Middle,	Meiden Surne	ma)		
arked o	5	FREDERICK								MGLISH				
7 is marke traumatic		19a. Informant's Nam	0	Type, Print)						I Route Numbe				
tem 27		JUANITA			not n		5 ACTO		DA	LTIMORE				
		20a. Method of Dispo		Removal from St		emetery, cren	netory or other	place)	CC	Data T 9	20c. Location	- City or 10	wn, State	
Important: If If any Injury or one		4 □ Donation 5			PAF	KWOOD	CEMETE	RY	1	997	PARKVI	le, MI		
mpor any in		21. Signature of Fune	ral Service Licer	nsee		22	. Name and Ad	dress of Facili	ty					
) = e o		Solvet	1.QL+	2		Ev	ANSCHAR	E L ME	MARIE	< par	HADEND	nRn 1	BALTO MI	_
/sician ledical	ı	23a. Part1. Enter the shock, or heart to shock the shock of heart to shock the shock of the shoc					Inf						Approximate Interval Betwee Onset and Dea	
aminer	П	resulting In death)		a		es e conseq		are III	~					
-	ner			D	chyd									
Du	Examiner	Sequentially list cond	itions.	b		as a conseq								
en a		Sequentially list cond if any, leading to imm ceuse. Enter Underly Ceuse (Disease or In	ediate	M	9/10	tritio	n							
he bu	lica	that initiated events resulting in death) La		C		as e conseq	uence of):							
attending physiclen and for use as the buriel-trensit	VMedical			d										
e atter	Physician/	Part II. Other significa	ent conditions o	ontributing to dea	th but not resi	ulting in the u	nderlying ceuse	given In Part	l.	23b. Dld to	obacco use c	ontribute to	the cause of o	death?
deteched		~								101	7es 2□ No	3 ☐ Prot	pably 477Un	known
5.6	d by									24a. Was	an autoney	24b W	era autopsy find	linas
been s	Completed									perfor		ave	allable prior to impletion of caus	
60 CM	mp											of	death?	
pag										1 🗆 Y	es 22 No	10	Yes 22 No	)
director, pag	Be	25. Wes case referred axaminer?	d to medicel	Hoppital					of Death	(Check only or	ne)			
this o	2	1 Yes 2 No	)	-		ER/Outpatien				ne 5 Rasid			1)	
After	Certification:	27. Menner of Death 1 Natural 2 Accident	5 Pending Investigation		Injury Dey Year)	28b. Time of injury		njuryet Work? I□Yes 2□		28d. Describe h	ow Injury occi	irred		
Nreci in by	artific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place o	f Injury - At ho , etc. (Specif)	me, ferm, str	eet, factory, off	се	2	28f. Location (S City or Tow		ber or Rura	l Route Number	r,
To the Funeral Dir		29a. Certifier	Certifying Ph	ysician: To the b	est of my know	wledge, death	occurred et th	time, dete ar	d place, a	and due to the o	ause(s) and n	nenner as st	eted.	
he Fu	edical	(Check only 2 one)	☐ Medical Exam  ———————————————————————————————————	niner: On the bas and manne	is of examinat r stated	ion and/or inv	estigation, in n	y opinion, dea	th occurre	ed at the time, o	late and place	, and due to	the cause(s)	
3 5	Z	29b. Signature and tit	e of certifier	/ /			29c. Llc	ense number		2	29d. Date sign	ed (Month,	Day, Year)	
F 8		19	//	/	2 -	3.	O.	454	75		10/8	97		
2 8		, ,												
- 1		30. Neme and address	s of person who	completed cause	of daath (Item	23a) (Type	Print)							
-)		30. Neme and addres				23a) (Type,	·	DA:-	6. M					au

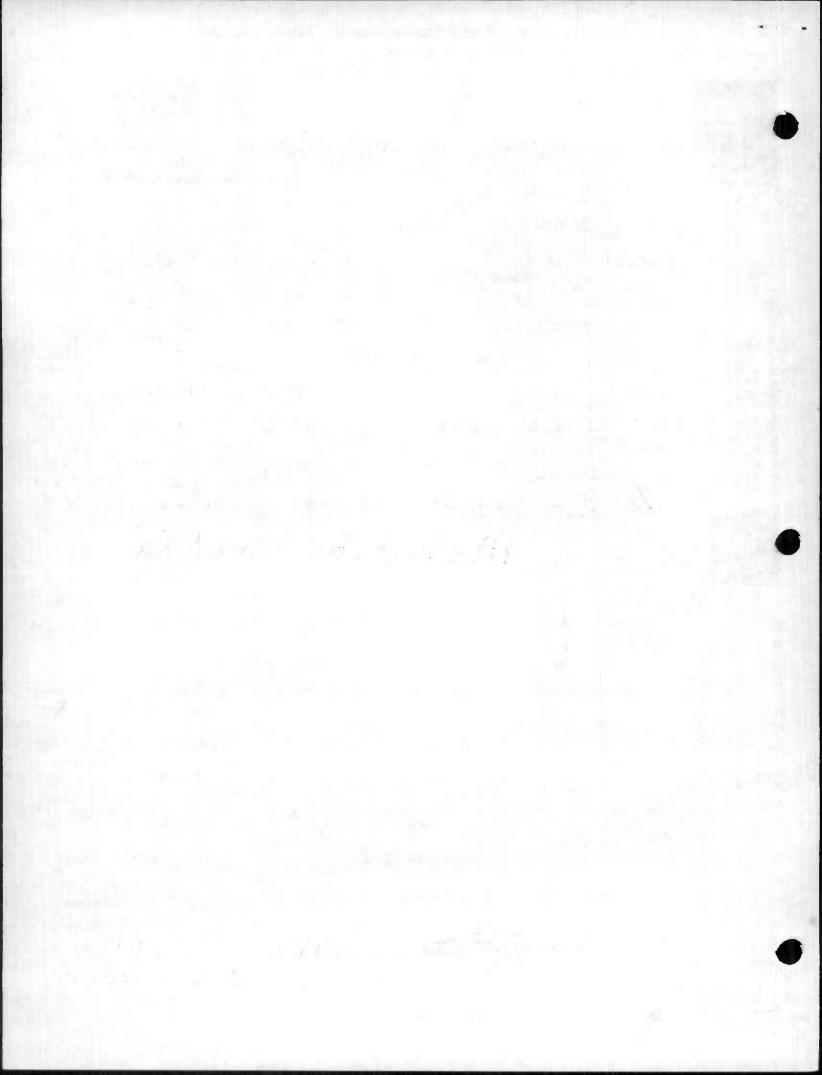


State of Maryland / Department of Health and Mental Hygiene

30748

				Certifica	ate of Death	R	eg. No.	
Dhysici		1. Decedent's Name (First, Middle, La	ist)			2. Date of Dee Month	th Day Yea	3. Time of Death
Physici- /Medic		DRace Mari	1 Rearney			Oct.	5 1997	4:30A
Examin		4a. Facility Name (If not institution give	e street and number)	1 1	4b. City, Town, o	or Location of Death	4c. County of De	eth
		Genesis da	rescare - La	IL RAVER	1 / Cul	SON	Balt	MORE
uneral		5. Social Security Number 6. S	Sex 7. Age (In yrs. 1 ☐ M 2 ☑ F	last birthday If Und  Yrs. Month	ler 1 Yeer   If Under 24 H s Deys Hours Mi	U. Date Of Dill	Year) 9. B	irthplace (State or Fore Country)
irector		Usuel Residence of Decedent		3× 113.		March 21	. 1915 M	aeyland
ž		10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Lim
28a-f show	0	Manufaced Balling	100	201101				1 ☐ Yes 2 ☑ 1
28a-f	Funeral Director	10e. Street and Number	ike Ci	101. 2	Zip Code	1	0g. Citizen of What (	Country?
23a or		2822 Pub Hil	1 01		212316		1181	
ma 23a	Jera	11. Marital Status	12. Wes Decedent Ever in U	,S. 13. Was Dec	edent of Hispanic Origin?	(Specify Yes or No-		nerican Indian,
or items		1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No		pecify Cuban, Mexican, Pu	erto Rican, etc.)	Black, Wi	
al', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1Ll Yes	2 No Specify:		Specify:	note
netur lice	Completed	15. Decadent's Ed (Specify only highest gra		16a. Decedent's Us	ual Occupation	vorking	16b. Kind of Busines	s/Industry
a la	nple	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	work done during most of w use retired)	ionary	Equitable	PRUST
1. 5 5 V	Co	12 yes	4 yes.	audite	X.		U	
and menter hygiene. is marked other than "natural", raumatic event, tra Heures Ex	Be	17. Father's Name (First, Middle, Last,	)		18. Mother's N	lame (First, Middle, i	Maiden Sumame)	
item 27 is marked other than other traumatic event, the M	P	JOHN L. Rea	eney		Auc	e M. M	1 Coma	\$
is m		19a. Informant's Name/Relationship (	Type, Printt)	19b. Mailing Addre	ss (Streat and Number or	Rural Route Number	r, City or Town, State	, Zip Code)
em 27 inther tr		AUCE CCEENE	val Sister	Placa of Disposition (N	is full ke	V. Calp	ly, Md	41204
or of		20a. Method of Disposition  1 ⊠Burial 2 □ Cremation 3 □	/	cemetery, cremetory or	other place)	Oct. 9	20¢ Location - City o	or rown, Steta
tant:		4 □ Donation 5 □ Other (Specif		ew Carrier	teal conceres	1997	Daltimo	es Maryle
Department of Health Important: If item 27 any injury or other ti once.		21. Signature of Funeral Servica Licer	1 1 110	22. Name	and Address of Facility	Evans Cl	rapel of 1	Lemore
3280		ARISHA -	1. Well X	1 8800	Harlord 1	ed Balt	emore M	d 21234
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one ceuse on each line.	h. Do not enter the me	ode of dying such es card	lac or respiretory arr	est,	Approximete Intervel Between Onset and Deetl
ysician Iedical		In a distance of the I	w.	1. 1.	the V	1 6	Co.	Onset and Deett
aminer		Immediate Cause (Final disease or condition resulting in death)	a 1116	400/40	CHC 1	21 Call	" Cal	
	9		Due to (d	or as e consequence o	i):			
dansit	Examiner	Comments to the same of the sa	b. Due to (c	or as a consequence of	0.			
n en riel-tr	Exa	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury	20010 (0	n as a consequence of	7-			
attending physician end for use es the buriel-transit	edical	that initiated events	C. Due to (o	or as a consequence of	):			
dg ph th se	Je d	resulting in deeth) Last	5001010		,.			
andin r use	M/UE		d					1
ed by the attendin deteched for use	Physician/	Pert II. Other algnificant conditions of	contributing to death but not res	ulting in the underlying	ceuse given in Part I.	23b. Did to	obacco use contribu	te to the cause of de
by th	, j					1□ Y	es 2 No 3	Probably 4 Unk
signed t	by I							
been si should	P P					24e. Was a perfor		<ul> <li>Were autopsy findin aveilable prior to</li> </ul>
8 0	ple							completion of cause of death?
ate he	Completed					1 🗆 Y	es alano	1 Yes 2 No
certificate rector, pag	Be	25. Was case referred to medical exeminer?			26. Place of D	eath (Check only or	10)	
this ce	To	1 Yes 2000	Hospital: 1 ☐ inpatient 2 ☐	ER/Outpatient 3□ 0	OOA Other: 4 Nursing	Home 5 Reside	ence 6 Other (Sp	pecify)
ter th		27. Manner of Death  1 Natural 5 Pending	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
- X - 2	atle	2 ☐ Accident Investigation	n	М	1 Yes 2 No			
268		3 Suicide 6 Could not b	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	bry, office	28f. Location (S City or Town	treet and Number or . n, State)	Rural Route Number,
Irector In by the	ŧ	- I Houstings						
ral Director	Certification:			wiedge, death occurre	d at the time, date and ple	ca, and due to the c	ause(s) and manner	es stated.
Funeral Director		29a. Certifier (Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of exemine	tion and/or Investigation	nn, in my opinion, death oc	curred at the time, d	ate and place, and o	
the Funeral Director  The Funeral Director  The Funeral Director  The Funeral Director	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of exemine and manner stated.	etion and/or Investigation	on, in my opinion, death oc			
within 42 hours and closelt.  To the Fuereis Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only 2 Medical Exam	niner: On the basis of exemine	etion and/or Investigation	on, in my opinion, death oc	2	9d Date signed /Mo	oth Day Year)
within 24 hours effer dea To the Funeral Director completely filled in by the	edical	29a. Certifier (Check only one)  29b. Signature and title of paddles	nlner: On the basis of exemine and manner stated.	ation and/or Investigation	on, in my opinion, death oc	2	9d Date signed /Mo	oth Day Year)
within 24 hours ener dea To the Funeral Director completely filled in by the	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nlner: On the basis of exemine and manner stated.	ation and/or Investigation	on, in my opinion, death oc	2	9d Date signed /Mo	

DHMH 16 Rev 6/95



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~	- #	U	V	- 8	-1	-

29d. Date signed (Month, Dey, Year)

OCT. 06, 1997

	RVIN G		art I 27 per MEC	G-752			yland /				lealth and N Death		giene Reg. No.	97 (	30749
			1. Decedent's Name (First	t, Middle, Les	it)	G. 7.	,					2. Date of Dec	ath		3. Time of Death
	Physic		Irvin	G.	Kenda	ell '						OCT.	5, Day	Year	8:58 AM
3	/Medi Exami		4a. Facility Neme (If not in	stitution, give	street end nu	ım <i>ber)</i>					4b. City, Town, or L				0100 111
И			2870 OLD E	LK NEC	K RD.						ELKTON		Ce	cil	
	Funeral Director		5. Social Security Number 215-80-3328	41	ex □ <b>X</b> M 2□ F		in yrs. last b	rthdey) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De Sept.	h y, Year) 9, 1960		e (Stete or Foreign
_	pu »		Usual Residence of Dece				0. 0. 7.								
	deeth with the Maryland ima 23e or 28e-f show	ctor	Maryland	Cecil		1	Oc. City, Tov E1k	ton	ation						Inside City Limits 1 ☐ Yes 2 📉 No
	th with the	al Director	10e. Street and Number 2870 Old El	k Neck	Road				10f. Zip	Code 2192	21		10g. Citizen of 1		
020	ours after dee	by Funeral	11. Marital Status  14 Never Married 2  3 Widowed 4 D		12. Was Dec Armed For 1 XYes If Yes, Gi Year or D	orces? 2 No ive	er in U,S.	If	/as Dece Yes, spe	cify Cuba	lispanic Origin? (Sp an, Mexicen, Puerto Specify:	ecify Yes or No Ricen, etc.)		ce - American ck, White, etc White	
21215-0020	within 72 hong.	Completed	15. Di (Specify only Elementery/Secondary		de completed)	) (1-4or 5+)		(Give k	O NOT u	ork done se retired	during most of work	ling	16b. Kind of B		
aryland 2	nd 2 should be file Ith and Mental Hy 27 is marked othe fraumatic event,	o Be Co	11 17. Fether's Name (First, I		2-11 6				abor	er	18. Mother's Nem		Maiden Sumen	tructio	711
2		ř	Irvin G			•	19	h Mailine	A ddrae	(Street	Lydia end Number or Run	I. Brow		State 7in Co	rdol o = 4 × ×
S			Tammy White		,										25411
ltimore,			20a. Method of Disposition  1 XBurial 2 Cren  4 Donetion 5 D	nation 3	Removal from		20b. Place cemete	of Dispos		me of other plea		Dete 10/8/97	20c. Location		, State
	Physician /Medical Examiner		23a. Pert1. Enter the dise shock, or heart fellur Immediate Ceuse (Final disease or condition resulting in death)	ase, or comp e. List only o	one ceuse on (	HEROS	/	not ente	DIOVA	se of dylr	Stockton ing, such as cerdiac	or respiratory ai	rest,	Ar	proximate terval Between nset and Death
	n #	ner				Du	ie to (or as a	consequ	ience or):						
,	sate be axecuted shysician and the bunal-transit	Examiner	Sequentially list conditions if any, leeding to Immedia cause. Enter Underlying Ceuse (Disease or injury	s, te	b. —	Du	e to (or as a	consequ	ence of):						1
8760,	ate b hysic the b	dlcal	that initiated events resulting in deeth) Last		C	Du	e to (or as a	consequ	ence of):						
9 ×	eath certific attending p	Φ.			d										
Box	ath ca thend or us	lan/			0.										
0	the death by the atter ached for u	Physician/M	Part II. Other significant of	onditions co	ntributing to d	leath but r	not resulting	in the und	derlying	euse giv	en In Part I.	23b. Did 1	obacco usa co	ntributa to th	e cause of death?
S, P.	gned b	by Ph										10	Yes 2 No	3 Probab	ly 4 Unknow
Record	aw requires is been sign 2 should be	Completed											en autopsy rmed?	availe	autopsy findings ble prior to letion of cause oth?
	: The icate h											1,20	/es 2□No	1 DCY	es 2 No
Vital	Physician: The lithis certificate harral director, paga	Be	25. Was cese referred to reseminer?		Hospital:					Oth	28. Place of Deat				
ō	E E E	To.	1 X Yes 2 No 27. Manner of Deeth		1 1 1	Inpatient	2 ER/O	utpatient Time of		JA	4 Li Nursing Ho	me 5 Resid			
Division	Iling After fune	Certification:	1 XX Naturel 5 🗆 2 🗆 Accident	Pending investigation Could not be	28e. Date (Mon			injury	М		k? Yes 2 □ No		now Injury occur		
2	afte Dir		4 Homicide	determined	28e. Place	e of Injury ling, etc. (	- At home, f Specify)	erm, stre	et, fector	y, office		281. Location (8 City or Tov	Street and Numb vn, Stete)	er or Hurei R	oute Number,
	n 24 hours n 24 hours ne Funeral	edical			iner: On the b		amination a				ne, date end plece, pinion, death occur				

State Registrar

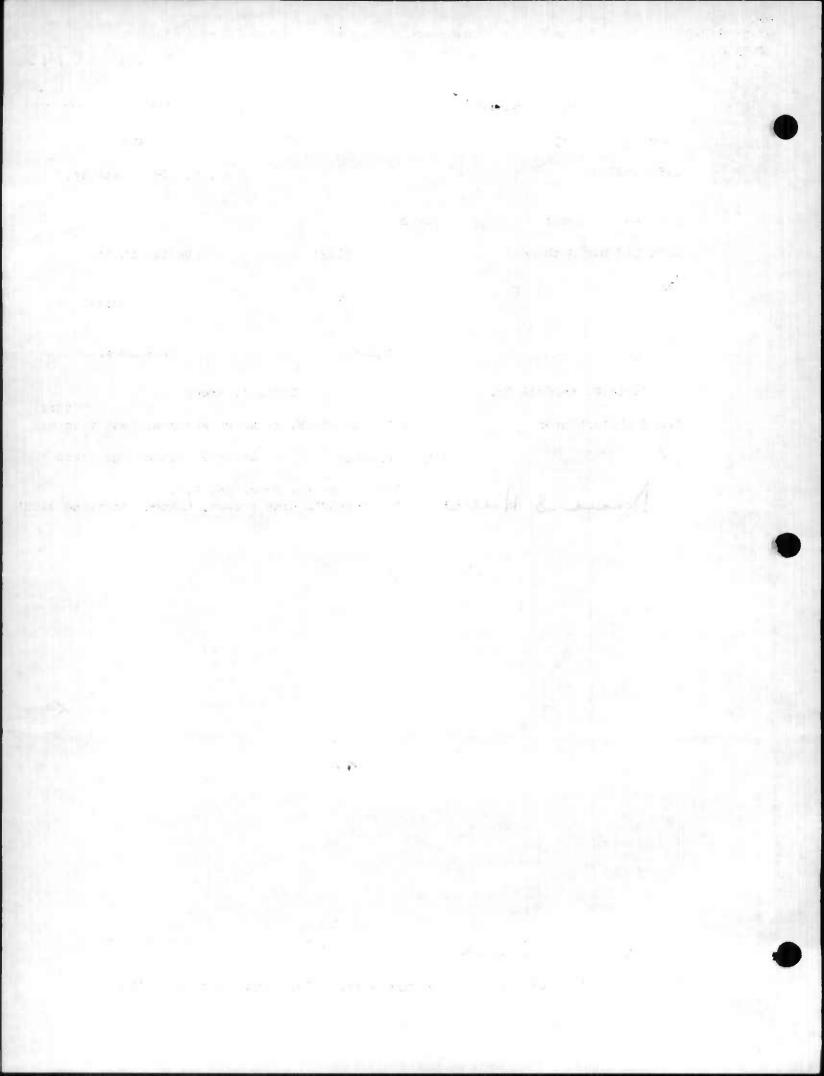
29b. Signeture end title of certifier

111 Penn Street, Baltimore, Maryland 21201
32. Registrar's Signature Julia Savidson-Randson

completed cause of death (Item 23a) (Type, Print)

29c. License number

O.C.M.E.

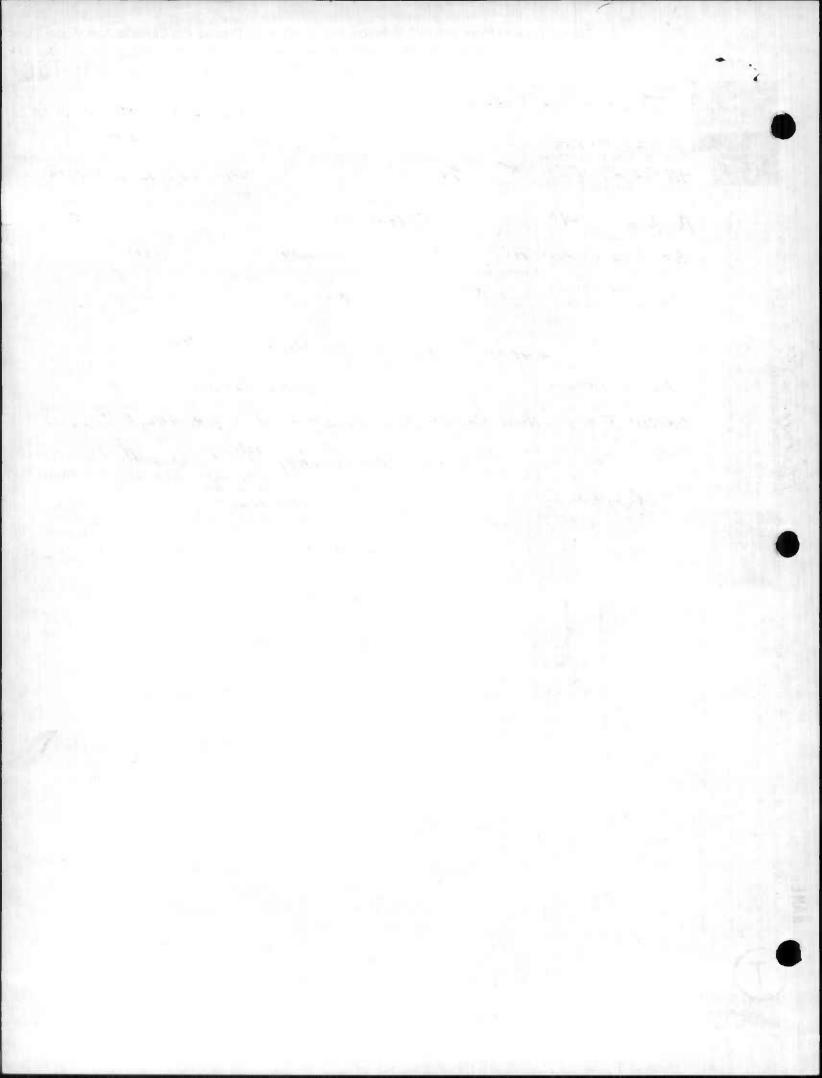


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth IHELMA STOVER LEE **Physician** Year October 05 1997 /Medical 06:05 am 4a. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** St.Agnes Hospital Baltimore If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) if Under 24 Hrs. Hours Min. Birthpleca (State or Foreign Country) **Funeral** 1 M 2 F 418-32-2964 26,1900 Yrs. Director ALABAMA Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at BALTIMORE 14 Tes 2 □ No Director Marylana 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3408 W. Caton 1517 21229 Completed by Funeral Wes Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Dates: ò 21215-0020 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Nursies Assistant 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry 2 YEARS Etementery/Secondary (0-12) 17. Fethar's Nema (First, Middle, Last) 18. Mothar's Nema (First, Middla, Maldan Surname) Be Pages 1 and 2 should be and Mental NOBLE STOUER SADIE CArson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a. rat: If Nam 27 is r DAUgnar 527 Sparkbing St. FAYEHEUILE, N.C. 28301 SHARIN JOHLSON-HAM'S 20b. Piece of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20e. Method of Disposition 12 Buriai 2 Cremetion 3 Removel from State 4 Donation 5 Othar (Specify) Istonsville, Mary Como WESTERN Stor Cemekry 22. Neme end Address of Fecifity CINA 21. Signature of Funerel Service Licensee 5040 REISTEISTEAN 23a. PertY. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Bleeding /Medical en hours Immediate Causa (Final disaase or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Physician/Medical Examiner Pulmonary The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of) Box 68760. Due to (or es e consaquence of): Anaemic Pert II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? lasemia 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 9 24b. Were sutopsy findings aveilable prior to Be Completed 24a. Wes sn eutopsy performed? completion of ceuse of deeth? 2 NO this certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was cese referred to medical 26. Plece of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? Medical Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred After 1 Neturet 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident filled in by the Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Spacify) To the Hospital or A within 24 hours efter To the Funeral Direc completely filled in by 4 I Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the causa(s) and menner es steted.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the causa(s) end manner stated. 29e. Certifier 29d. Date signed (Month, Day, Year)
OCODEL 5, 19 29b. Signeture end title of certifier 29c. Licanse number Saleen Mohammad D40610 30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print) ST. AGNES ER MOHAMMAD SALEEM

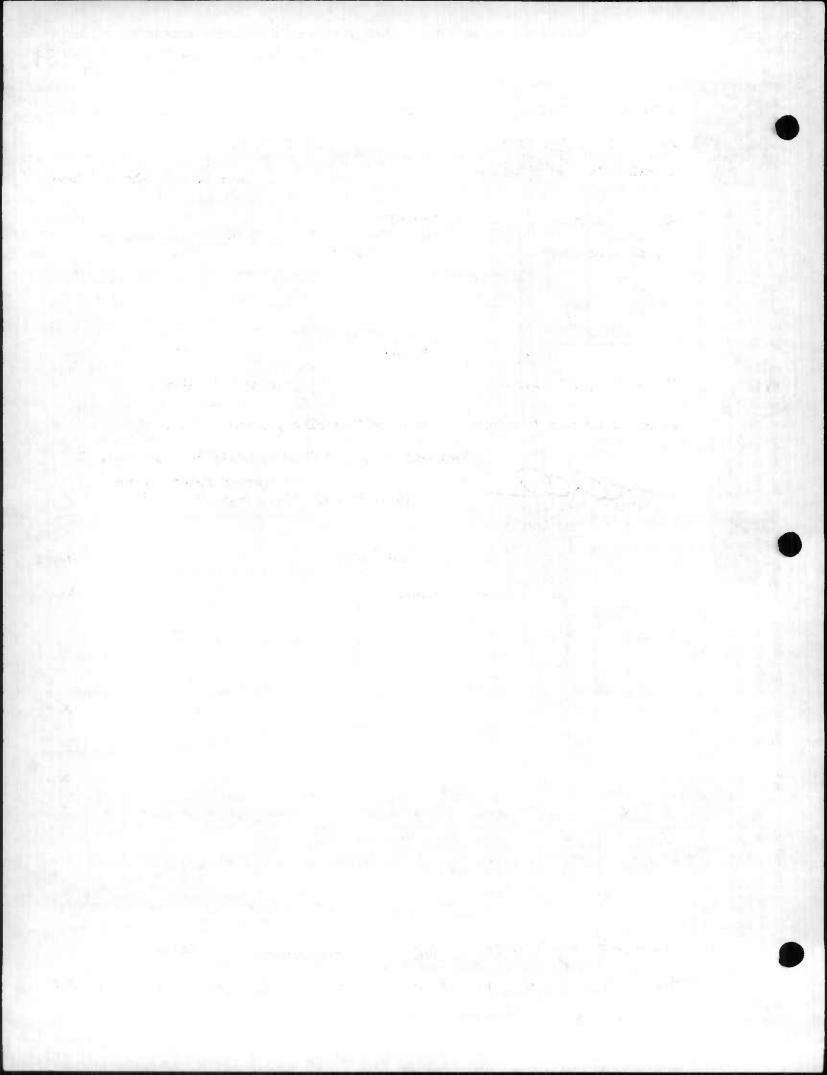
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State of Maryland / Department of Health and Mental Hygiene 97

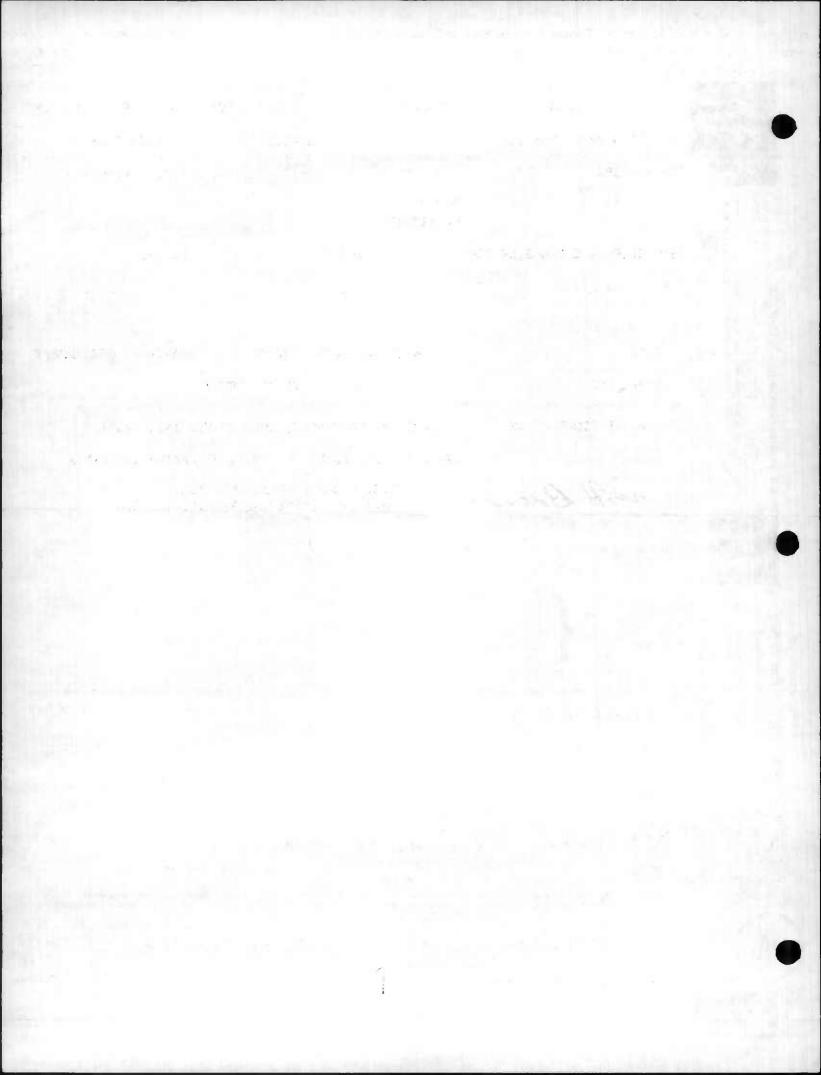
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						Ce	rtificat	e of	Death	•		Reg. No.	7 1	00	/ 0 1
		1. Decedant's Name (First,	Middla, L	ast)							2. Deta of De	eth	1,023	3. Time	of Deeth
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/Med Exami		4e. Fecility Name (If not ins			um <i>ber</i> )				4b. City, To	own, or Lo	ocation of Deat		y of Death		A
Laurin	-	THE JOHNS H							BALTI			N/A			
Funeral Director		5. Sociel Security Number 180–12–4433		Sex 1□M 2√xF	7. Age (In yrs. 78	last birthday; Yrs.	If Under Months	Days		Min.	8. Date of Bir (Month, De June 1	ay, Year)		iplace (Stete untry) Isla	
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ner death with t herre 25e or 3 ner must be n	Funeral Director	10e. Street and Number 8 Pine Bark	Cou	rt			10f. Zip	030				10g. Citizen of USA	Whet Cou	intry?	
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5-0 72 ho	Completed			Education rede completed	1	16a. Dece	dent's Usu	el Occu	pation	t of work	ina	16b. Kind of E	3usiness/Ir	ndustry	
2	nple	Elamantary/Secondary (0	-		(1-4or 5+)			se retire	during mos	it of work	arig				
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Some		19e. informant's Name/Rei	tionship	(Type, Print)		19b. Meill	ng Addrass	(Stree	t end Numb	er or Rur	al Route Numb	er, City or Town	, Stete, Zi	ip Coda)	
N DEL		Janney Wrig	ht L	ee/Daugl	hter	10520	) Wil	mar	Place	, Co	ckeysv:	ille, M	210	30	
or I and of Health		20e. Mathod of Disposition			20b. F	Plece of Dispo ematary, cre	osition (Nam	ne of	ice)	T	Dete	20c. Location	- City or T	own, Stata	
Baltimore emit. Pages 1. Appartment of Hs mportant. If then ny injury or oth		1- Buriai 2 ☐ Crema 4 ☐ Donetion 5 ☐ Ott								em 1	0/11/1	997 G1	encoe	, MD	
B mile market south		21. Signature of Funeral Se	me yes	578500		2	2. Nama ar	d Addr	ess of Fecili	ty Le	emmon Fi	ineral l	Home		
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BO Bath c ettend for us	Physician/			d											
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COTC requir	Completed										perlo	omed?	OI OI	velleble prio ompletion o	rto
I Rec	d m												of	f death?	
= F # 6											112	Yes 2□No	1	☐ Yes 2	No
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ai di	<u>۲</u>	1 ☐ Yes 25 No 27. Manner of Death		114		ER/Outpatie						dence 8 Ot		ify)	
The state of the s	Certification:	1 Neturei 5 □ P	ending vestigetio		ith, Dey Year)	28b. Tima o injury	M	8c. inju Wo	rk? ]Yes 2∐		250. Describe	how Injury occu	rrea		
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Div To the Hospital or within 24 hours efter To the Funeral Dire completely filled in	edical		lical Exa	miner: On the b	e best of my kno- lesis of axamine nnar stated.	tion end/or in	vastigetion	in my	ma, data an opinion, dea	ith occurr	red at the time,	data and place	, and dua	to tha cause	i(S)
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8)		30. Name end eddress of pe			sa of death (Itam			)	11	1	p la	0 104	Page - 1	M 0:	
		Misop Han 31. Dete filed (Month, Dey,	60	100	ote St	John	s Hop	Kins	17-50	ital,	Bultim	OM, MO	2/2/	11 - 91	06
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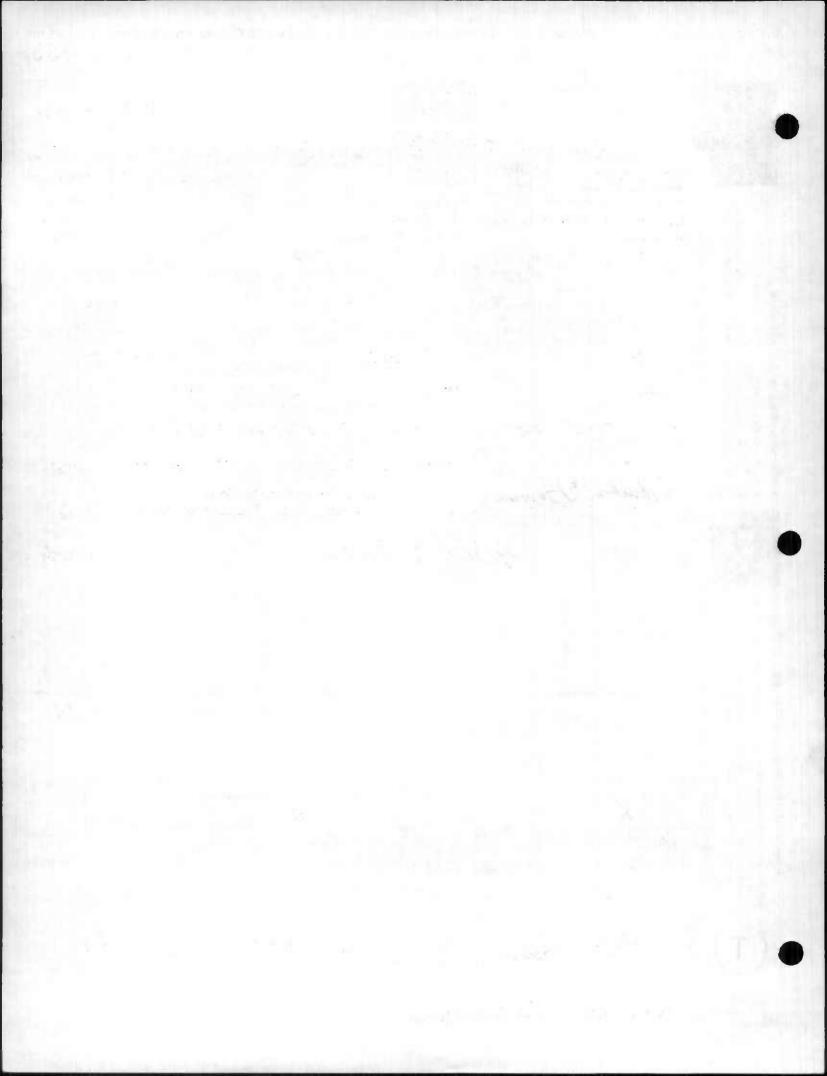
					Ce	rtificate	of Death	R	eg. No.	1	0070	J (_
Physician		1. Decedant'a Nama (First, Middla, Last)						2. Data of Death Month Day Yaar  3. Tima of Death				
Physician /Medical			RAHAM		LOGAN		-	OCT.	6	97	3:28	PM
Examine	r	4a. Facility Name (If not institution, give street and number)  PRINCE GEORGES HOSPITAL  4b. City, Town, or to the control of							PRINCE GEORGES			
Funeral Director		5. Social Security Number 226–26–1392		Aga (In yrs. last birthday) 76 Yrs.  If Under 1 Year if Under 24 Hr Months Days Hours Mir			8. Data of Birth (Month, Dey, JAN. 3	8. Data of Birth (Month, Dey, Year) JAN . 3 1921 9. Birthplaca (Stata or Fora Country) VIRGINIA				
land	Usual Rasidance of Decedant  10a. Stata 10b. County 10c. City, Town or Location									10	d. Insida Cit	ty Limits
the Marylan 28a-f show notified at	ctor	D.C. WASHINGTON							1 Yas 2 N			
deeth with the Maryland ms 23s or 28s-f show	Funeral Director	10e. Street end Number 1820 CLYESDALE PLACE, NW #200 200					DOOD9 10g. Citizan of Wi U.S.A.			What Count	hat Country?	
urs after al', or ite	2	11. Marital Status  1. Navar Married 2 Mar. 3 Widowed 4 Divorced	riad 1 Tas	12. Was Decedant Evar in U,S. Armed Forces? 1 □ Yas 2 ὧ No If Yas, Giva Yaar or Datas:			t of Hispanic Origin? (: Cuban, Maxican, Pua No Specify:			Race - American Indian, Black, Whita, atc. BLACK		
n 72 hours natural',	etec	15. Decedar (Specify only higha	it's Education st grada complate	location 16		16e. Decedant's Usual Occupation (Giva kind of work dona during most of work			16b. Kind of Bu	of Businass/Industry		
within	Completed	Elementary/Secondery (0-12) Collaga (1-4or 5+)			'lifa. DO NOT usa retired)  NATIONAL PARK SERV			CE MARY		YLAND GOVERNMENT		
e filed el Hygie vent,	D P	17. Fathar's Nama (First, Middla, Last)						ama (First, Middla, Maidan Surnama)				
Mentel Mentel arked o	0	MATTHEW LOGAN VIRGI						L PETTY				
2 should be and Mentel is marked surratic ev		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Addrass (S	traat and Numbar or F	r Rural Routa Number, City or Town, Stata, Zip Coda)				
is 1 and 2 should be filed If Heelth and Mentel Hyg item 27 is marked other other traumatic event,		CATHERINE STON	E-NIECE				Y ROAD, CH	ATHAM VIR	GINIA	24531		
age ant o fit: If i	20a. Mathod of Disposition  1 \ Burial 2 \ Cramation 3 \ Removal from State  4 \ Donation 5 \ Othar (Spacify)  20b. Piaca of Disposition (Nama of cematary, cramatory or othar place)  HIGHLAND BURN PARK  20c. Location - City or cematary, cramatory or othar place)  CHATHAM, VIR											
permit. Page Depertment of Important: If any injury or once.		21. Signatura of Funaral Sarvice Liberage  22. Nama and Addrass of Facility  W.H. BACON FUNERAL HOME INC.  3447 14TH STREET, NW WASH, D.C. 20010										
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Causa (Final disease or condition resulting in death)	c or raspiratory erro	aspiratory errest,			e ween Death					
and il-transit	Saquantially list conditions, if any, leeding to immadiata cause. Enter Underlying Ceusa (Disaasa or injury c.								1			
ing physicia e es the bu	Medical	cause. Enter Underlying Ceusa (Disaasa or injury that initiated evants rasulting in daath) Last  Dua to (or as a consequence of):										17
seeth certific ettending pl d for use es t	Clar											
t the	Fnysk	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Africal fibralian							23b. Did tobacco use contribute to the cause of de			
8 Pg 4	Completed by	- COPD	)					24a. Was a parforr	n autopsy ned?	con	ra autopsy fi llable prior to appletion of ca laath?	indings o ausa
The law								1 □ Ya	is 2 No	10	Yas 2	No
ysician: The sectificate director, pag	9	25. Was casa refarred to medica exeminar?	Ed. Face of Data ( Jordan Cong Cita)									
2 00	0	1 ☐ Yas 2 No		1 Linpatient 2 C/EH/Outpatient 3Li DOA   4Li Nursin				Homa 5 ☐ Rasidanca 6 ☐ Other (Specify)				
Ing P	100	7. Menner of Deeth 1 D Natural 5 ☐ Pending		a of Injury onth, Day Year)	28b. Tima o Injury		jury at Vork?	28d. Dascriba how injury occurred				
Hospital or Attending Ph 24 hours effar dash. Funeral Director: Affer th stely filled in by the funeral	Certificat	2 Accident 3 Suicida 4 Homicide  invastigation 6 Could not be determined  A. N A M 1 Yes 2 No 28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)						N. A.  28f. Location (Street and Number or Rural Routa Number, City or Town, State)  N. A.				
Hospital 24 hours Funeral pately filled	dical	29a. Cartifiar (Check only one)  29a. Cartifiar (Check only one)  Contifying Physician: To the best of my knowledga, daath occurred at the tima, data and place, and dua to the causa(s) and manner as stated.  Check only one)  Contifying Physician: To the best of my knowledga, daath occurred at the tima, data and place, and dua to the causa one)  Contifying Physician: To the best of my knowledga, daath occurred at the tima, data and place, and dua to the causa one)  Check only one)										)
A Samo		20h Cignature and title of partition							29d. Data signed (Month, Day, Year)  Spendu			
13.		30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)  SARDAR BAHADUR MD MANOR CARE WHEATON - 11901 GRONGIA: AW Wheaton MD-2090										
State		31. Data filed (Month, Day, Year)		Registrar's Sig								



State of Maryland / Department of Health and Mental Hygiene 97

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		1. Decedent's Name (First, Mic	ddla I ac	- 43													
riciai												2. Date of	of Death	Dev	Year	3. Tir	ne of Death
icia: dica	al -	ELIZABETH I				IUSGRO	)VE					Octo	ber	4, 19		5:	00 PM
nine	_	4a. Facility Name (If not institut	tion, give	street end nu	um <i>ber</i> )				4	b. City, To	wn, or Lo	ocation of I	Death	4c. County	of Deat	h	
		MANOR CARE								TOW	SON					RE CO	
al		5. Sociel Security Number	6. Se	ex □M 2.FF		in yrs. last l	W 1000	Months Months	Days	If Under Hours	Min.	8. Dete of	of Birth h, Dey, Ye	par)	9. Birti Co	hplaca (Si untry)	ete or Foreig
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	- 1	Usual Residence of Decedent  10a. State 10b. Cour	nty		10	0c. City, To	wn or Lo	cation				_				10d. Insi	de City Limit
	ō	Maryland Balt:	imor	e Count	+ x7		Tows	on									Yee 2X N
	Director	10e. Street and Number	LINOL	c coun	Ly		TOWS	Terror	ip Code				100	. Citizen of \	What Co		21
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ľ		19a. Informent's Name/Relatio	nship (7	ype, Print)		15	9b. Maliin	ng Addres	s (Street	end Numbe	r or Run	al Route N	lumber, C	ity or Town,	Stete, 2	(ip Code)	
		Julia M. Taylo	or.	Daughte	er		P.O.	Box	- 21	Ride	rwoo	d Ma	arvla	and 21	130		
		20a. Method of Disposition	-	9		20b. Place	of Dispos	sition (Ne	ome of other piece	e)	2.1000	Date	200	and 21 c. Location -	City or	Town, Sta	te
		1  Burial 2  Cremetion 4  Donation 5  Other			State						-x7   1	10/8/	07 T	uther	-: 11.	o Ma	arri ar
		21. Signature of Fungral Service	Digony Ligony	596		Dace	22	. Name a	nd Addre	ss of Facili	y	LUIUI		achery	V	علتا	путаг
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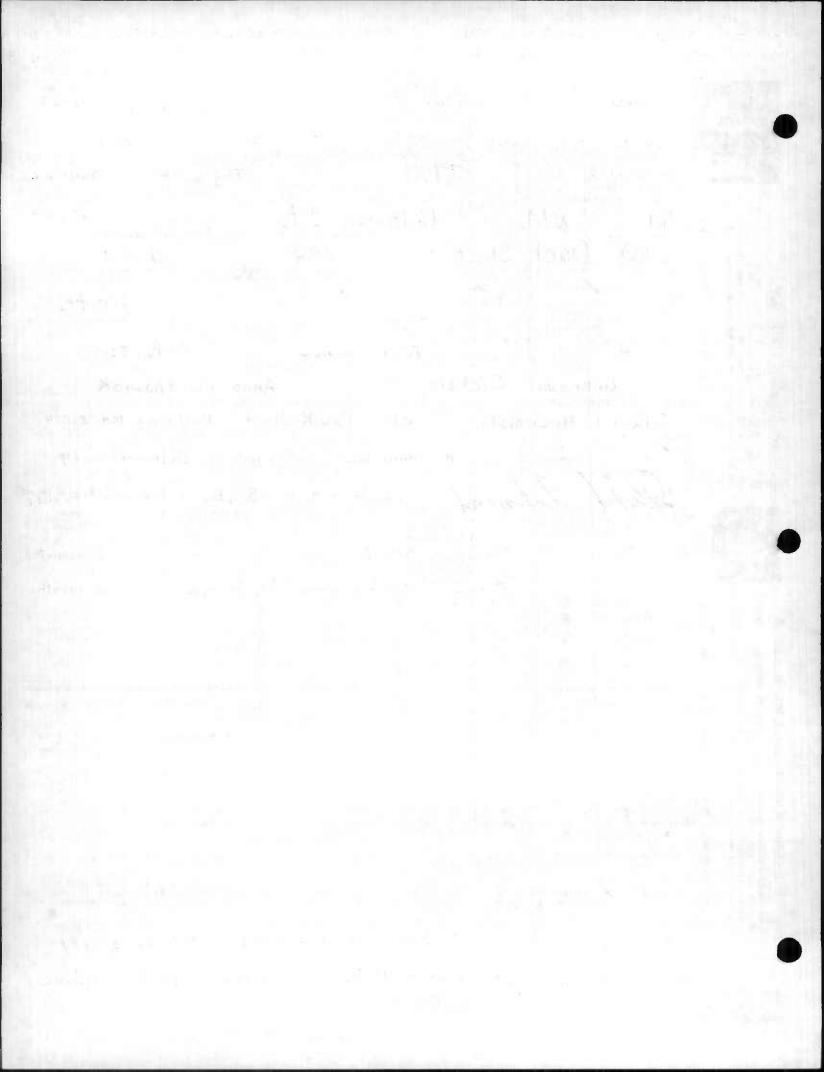


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State of Maryland / Department of Health and Mental Hygiene 9.7 30754

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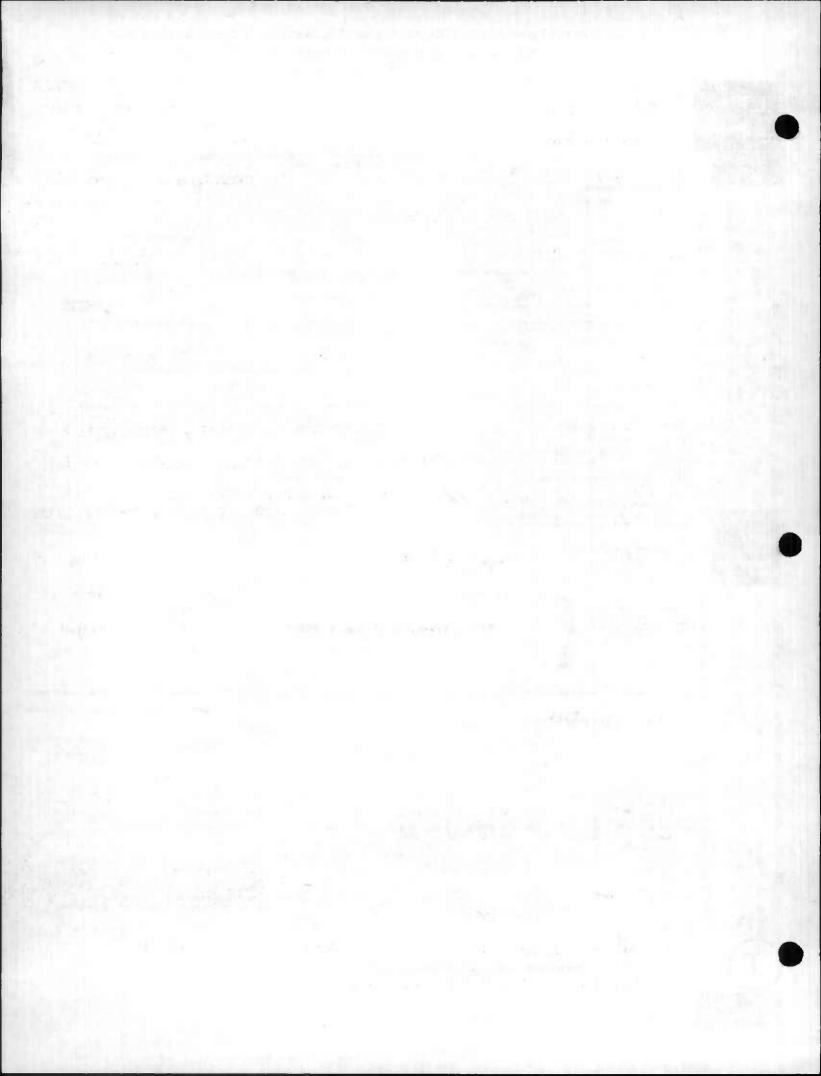
DHMH 16 Rev 6/95



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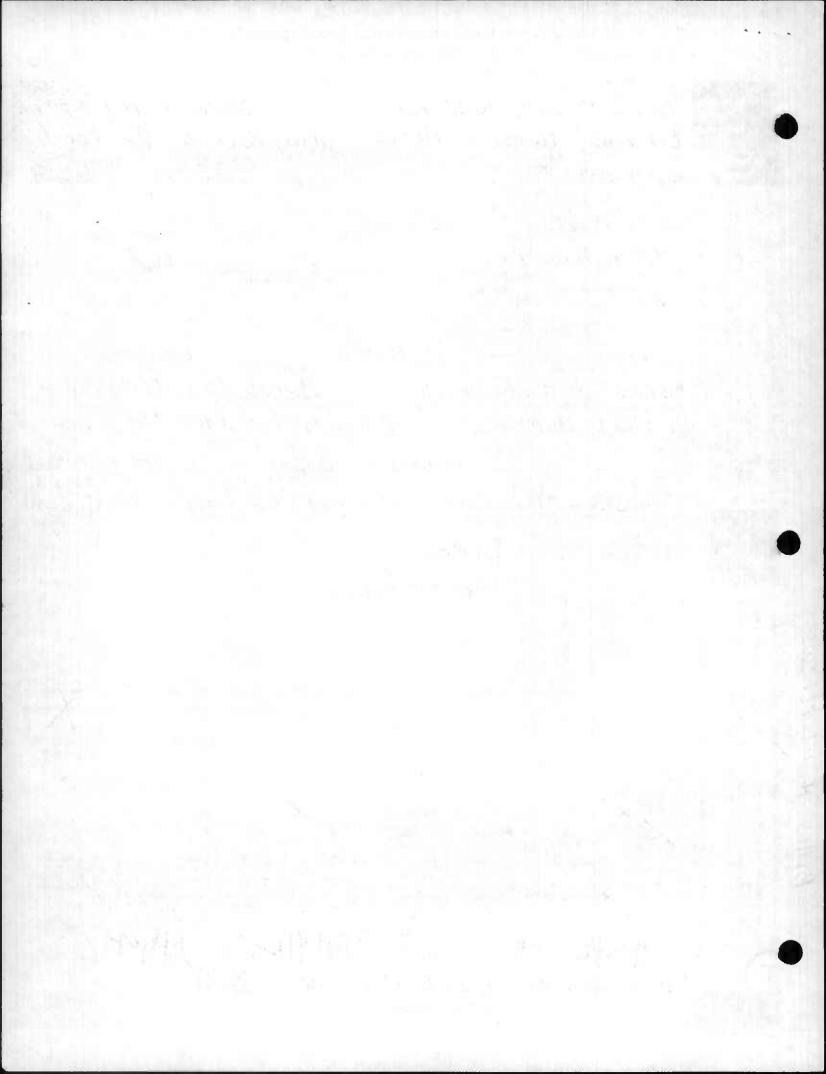
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Niawatha 3:30 pm Ctober /Medical 4e. Feçility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death Examiner Nursing +1ZENS Grace Havre de. If Under 1 Year Months Deys If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign 1 XM 2□ F 235-18-2847 Usuel Residence of Decedent Yrs. Director SINIG the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Menylan Department of Health and Mentel Hygiane. Important: If item 27 is marked other than "naturel", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Expresses must be not listed. 1 ☐ Yes 2 No Director Maryland 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 21050 Funeral Race - American Indien, Bieck, White, etc, Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried Maryland 21215-0020 Specify: White p 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 YRS 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number of Rural Route Number, City or Town, State, Zip Code) theus Baltimore, 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removei from State 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funeral Servica Licensed 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respire shock, or heart feilure. List only one cause on each line. Physician NEWTOMIA /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner e to (or es e consequence of): Examiner DISERSE physiclen end the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): ed by the attending detached for use as Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 Probably Unknown by been si 24e. Was en autopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed hes 2 No After this certificete 1 Yes director, 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Neturel 5 Pending investigation 1 Tes 2 🗆 No 2□ Accident or Attendi 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homlcide To the Hospital within 24 hours e To the Funeral D 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner stated. 29a. Certifier 29b. Signeture end title of gertifier 29d. Dete signed (Month, Dey, Year) 8 10 9 erson who completed cause of deeth (Item 23e) (Type, Print) 0

DHMH 16 Rev 6/95

State Registrar

Matthews



State of Maryland / Department of Health and Mental Hygiene

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permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. Important: If item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, it is Medical Examiner man be notified at

Baltimore, Maryland 21215-0020

Physicia /Medica Examine

To the Hospital or Attanding Physician: The law requires thet the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this cartificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Division of Vital Records, P.O. Box 68760,

Regi DHMH 16 Rev 6/95

					C	ertifica	ate of	Death			Reg. No.	1	JU	131
	1. Decedent's Name (First, I	Middle, Lest	)		Late.					2. Date of De	eath		3. Ti	me of Death
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Г	5. Social Security Number	6. Se		7. Age (In yr.	s. lest birthde		der 1 Year	If Under	24 Hrs.	8. Date of Big	rth	9. Birtho	place (S	itate or Foreign
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	21. Signature of Funeral Ser	vice Licepe	16	0				ess of Facili	ty					
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	SHOCK, OF Heart failure.	List only of	ia campa ou c	each line.								- 1		al Between and Death
	Immediate Cause (Final					-4	_ ^	la .	-1					
	disease or condition resulting in death)	8	a. Gui	nshot				hea	0		-	-		
ler				Due to	(or as a cons	sequenca o	r):					- 8		
Examiner			D. —	Due to	(or as a cons	,	٥٠.					1	-	
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Completed by										24a Was	an autopsy	24b. W	ere euto	opsy findings
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:uc	27. Manner of Death 1 □ Natural 5 □ Pe	anding	28a. Date (Mon	of Injury hth, Dey Year)	28b. Time Injun		28c. Inju Wo	ry at		28d. Describe	how Injury occur	red		
Sati	2 Accident	vestigation		10-8-97		M		Yes 2.40	No	Subire	+ was :	Shot	-	
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Me	29b. Signature end title of ca	rtifier		1		12	9c. Licens	se number			29d. Date signe	d (Month,	Day, Ye	par)
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State of Maryland / Department of Health and Mental Hygiene

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/Medi Exami		4a. Fecility Nema (If not institution, g				4b. City, Town	, or Location of Deal		TEX.	1900 A
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pspit hour ner ny filli		29e. Certifiar 1 Certifying F	hysicien: To the bes	t of my knowledge,	deeth occurred et t	ha tima, data end p	eleca, end due to the	cause(s) end m	enner es stated	d.
He Fu	edicai	(Check only one) Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cand menner stated.								
Divisit  To the Hospital or Attent within 24 hours after deell To the Funeral Director: completely filled in by the	M	29b. Signeture and title of certifier	4		29c. L	9c. Licanse number 29d. Dete signed (Month, Day, Yea			, Year)	
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State of Maryland / Department of Health and Mental Hygiene 30759 Certificate of Death 1. Decedant's Neme (First, Middla, Last) 3. Time of Death 2. Dete of Deeth Dey 9 1997 **Physician** MARLO 03:45 MATTHEWS OCTOBER /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth MERCY MEDICAL CENTER BALTIMORE It Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral**  Birthpiece (State or Foreign Country) 214-80-3669 Director MARCH 22, 1973 MARYLAND Usual Residence of Dacadant 10e. Steta 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at 1 Yes 2 No Director MARYLAND N/ABALTIMBRE CITY 10e. Straat and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21223 SOUTH SCHROEDER STREET itams 23a UNITED STATES Funeral Wes Decadent Ever in U,S. Armed Forces?

1 Yes 2 No It Yes, Give Yeer or Dates: Was Decadant of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien Bleck, Whita, atc. illed within 72 hours efter 1 Never Married 2 Marriad Baltimore, Maryland 21215-0020 natural', or 1□Yes 2 No Specify. Specify: DLA-CK þ 3 ☐ Widowed 4 ☐ Divorced Completed d other than "natu 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) al Hygiene. College (1-4or 5+) 12th N/A permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) Be Melvin J. Matthews Rose A. Fortson P 19a. Interment's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Melvin Matthews 3704 Courtleigh Drive, Randallstown, MD 20b. Piece of Disposition (Nema of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 № Burial 2 Cramation 3 Ramovel from State King Memorial Park 10/14 4 ☐ Donetion 5 ☐ Othar (Specify) Randallstown, MD 21. Signeture of Funarel Service Light 22. Nama and Address of Fecility & SON FUNERAL HOME, LEROY O. DYETT 4600 Liberty Heights Ave., Balto., MD21207 or complications that desaid the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, ist only one cause on each line. Approximete Intervel Batween Onset and Death **Physician** Immediete Causa (Finel disaasa or condition resulting In death) /Medical RESPIRATORY Examiner Due to (or as e consequance ot): Examiner PULMONARY EDEMA Sequentially list conditions, if any, leeding to immediata ceuse. Enter Underlying Ceusa (Diseese or Injury thet initiated avants resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, I or Attending Physicien: The law requires that the death certificate be effer death.

Director: After this certificate hes been signed by the ettending physicial of in by the funeral director, page 2 should be detached for use as the bun Physician/Medicai Due to (or as e consequance of): CARCINOMA PERVICAL Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by Completed 24b. Were eutopsy tindings eveilebia prior to 24e. Wes en autopsy completion of ceusa of daath? 2 No 1 ☐ Yes 2 No 1 Yes 25. Wes cesa reterred to madicel exeminer? Be 26. Plece of Deeth (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Daath 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of Injury 28c. Injury et Work? 28d. Dascribe how injury occurred 5 Panding Investigation 1 Yes 2 No 2 Accident 6 Could not ba 3 Sulcide 28a. Plece of Injury - At homa, term, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicida filled in I Hospital 24 hours 6 24 hours 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and piece, end due to tha causa(s) and mennar as stated.

2 Medical Examinar: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred at the time, data and piece, and due to the causa(s) end manner statad. 29e. Cartifiar Medical pletely f To the 29b. Signeture end title of certifia. 29d. Date signed (Month, Day, Year) 29c. License number

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BROWN MD AND MERCY

OCTOBER 9, 1997

State Registrar

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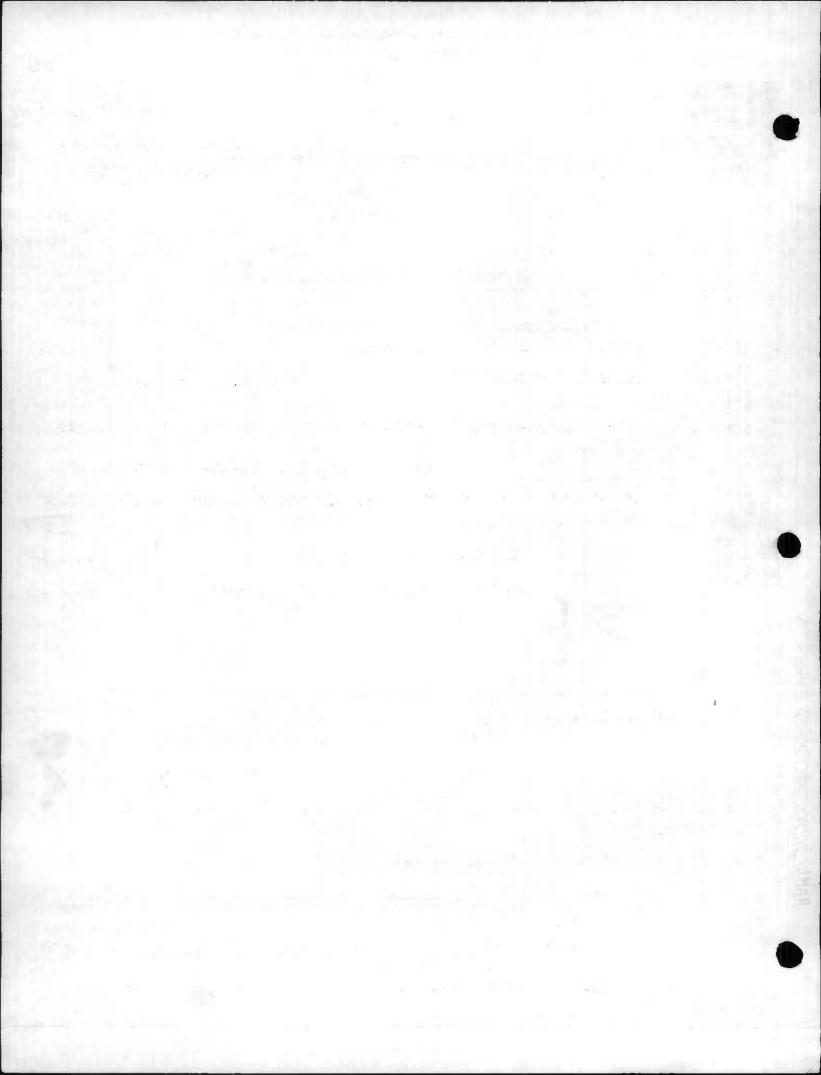
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physic /Medi	cal	1. Decedant's Nama (First, Middla,  JACKIE  49. Feellin, Nama (If not Institution)	BERNA		AY	NOR	4b. City, Town, or L	2. Data of De Month	P. 07	Gart T	3. Time of Death
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Anyland show	or	Usual Rasidance of Dacedent  10e. Steta 10b. County  MD	na	10c. City, To		cation TIMORE				10	Od. Insida City Limits 1 □ ₩ & 2 □ No
h with the A	Funeral Director	10e. Street end Number 4916 LINDS	AY ROAD			10f. Zip Coda	21229		10g. Citizan of UNITEI		
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be life other overt	To Be Co	17. Father's Nama (First, Middla, La CLARENCE	MAYNOR				18. Mother's Nam		, Malden Sumar PORTE		
2 2 2 2		19a. informant's Neme/Ralationship MARY MAY	(Type, Print) NOR- WIF		9b. Mailin		and Number or Ru				
Baltimore, N pemit. Pages 1 and Department of Health Important: If item 27 any injury or other to once.		20e. Mathod of Disposition  Survival 2 Cramation 3 4 Donation 5 Other (Spe 21. Signature of Funeral Service Lic	cify)	20b. Placa camat	of Dispos	ition (Nama of atory or other pla S MEM Nama and Addra	ca)	Date	20c. Location	City or Tov	wn, Stata
box 68760, death certificate be associted e attending physician and ind for use as the burial-transit	/Medical Examiner	Immediata Cause (Finel diseasa or condition rasulting in death)  Sequentially list conditions, if any, leeding to immediate causa. Entar Undarlying Ceusa (Diseasa or Injury that initiated avents rasulting in death) Last	6. Svdd 6. Arfl 6.	Due to (or as a	e consequ	vence of):	n rong v	essel	disce	ye.	Thour 5 years
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of Vital Physician: The this certificate rail director, pa	To Be	25. Was case refarred to medical axaminer?  1 Yas 2 No	Hospital:	tiant 2 ER/C	Outnation	3□ DOA Oth	26. Place of Dea		dance 6 Ott	ar (Specify	1
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Division  To the Hospital or Attendit within 24 hours after death.  To the Funeral Director: A  completely filled in by the fu	Medical	one) 2 Madical Ex	Physician: To the best aminer: On the bests and manner	of axamination a	ge, daeth ind/or inv	astigation, in my o	opinion, deeth occur	and dua to the red at tha tima,	data and place,	and dua to	tha cause(s)
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Sta Registi		OCT 1	1997	Julia Davi	dson-	fandell.					

DHMH 16 Rev 6/95

NAME: JACKIE BERNARD MAYNUR



97-5654-045 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene SHAUNIA MILBOURNE Items 23a part I,27 per MEO G-752 10/17/97 dh Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month OCT. Day 1997 Year 3, 1722 PM LOOURNE 1001c haunia /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL HOSPITAL E.R. SALISBURY
If Under 24 Hrs. WICOMICO 5. Social Security Number If Under 1 Yeer Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 215-47-922 Yrs **Director** Usual Residence of Decedent 10a State 10c. City, Town or Location 28a-f show 10d. Inside City Limits Westover 1 Yes 2 No 10f. Zip Code 10g Citizen of What Country? ŏ Walt 31890 218 items 23a Johnson Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 (No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 Yes 2 No by Specify. 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) NA 17. Father's Name (First, Middle, Last) nt: If item 27 is marked 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Micheal **15.** informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Milbourno/Mother 31890 Walt Westover, MD 2 20c. Location - City or Town, State Johnson RD havon A. MD 31811 20a. Method of Disposition

1 Burial 2 Cremetion 3 Removal from State Date Department of H important: If ite eny injury or ott Westover, MD John Wesely 10-7-97 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee and Address of Facility hony E. Wald Functed 2. Name and Add 30639 Hampden Ave. Princess Anne, MS 21853 he death. Do not enter the mode of dying, su Approximate interval Between Onset and Death Physician Immediate Cause (Final **ASTHMA** diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Physician/Medical Examiner that the death certificate be executed -tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of) USB P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? page 2 12 Yes 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Yes 2□ No 1 ☐ Inpatient 2 XX R/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation XX Netural death. 1 ☐ Yes 2 ☐ No 2 Accident efter death in by the 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year) OCT. 4, 1997

Records. Division of Vital within 24 hours of To the Funeral D completely filled To the

> State Registrar

296. Slo

30. Name

e and title of certifie

OCT

> YN

111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Davidson 1 0 1997

d address of person who completed cause of death (Item 23a) (Type, Print)

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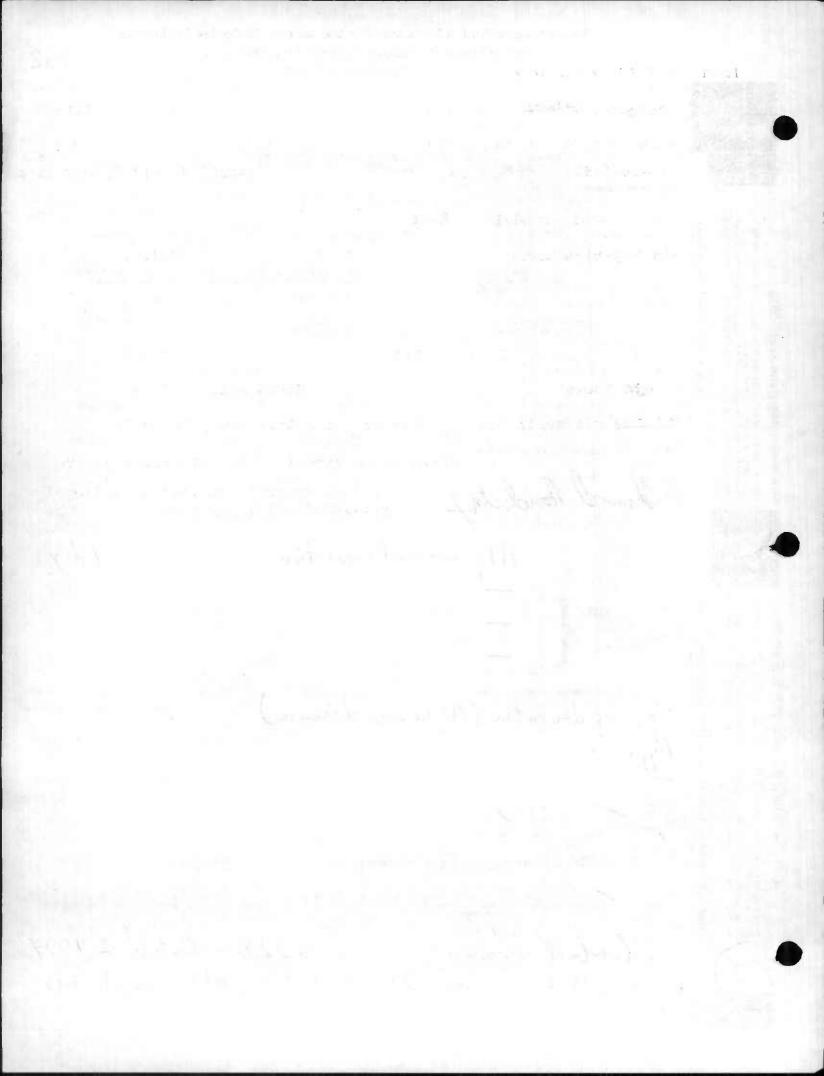
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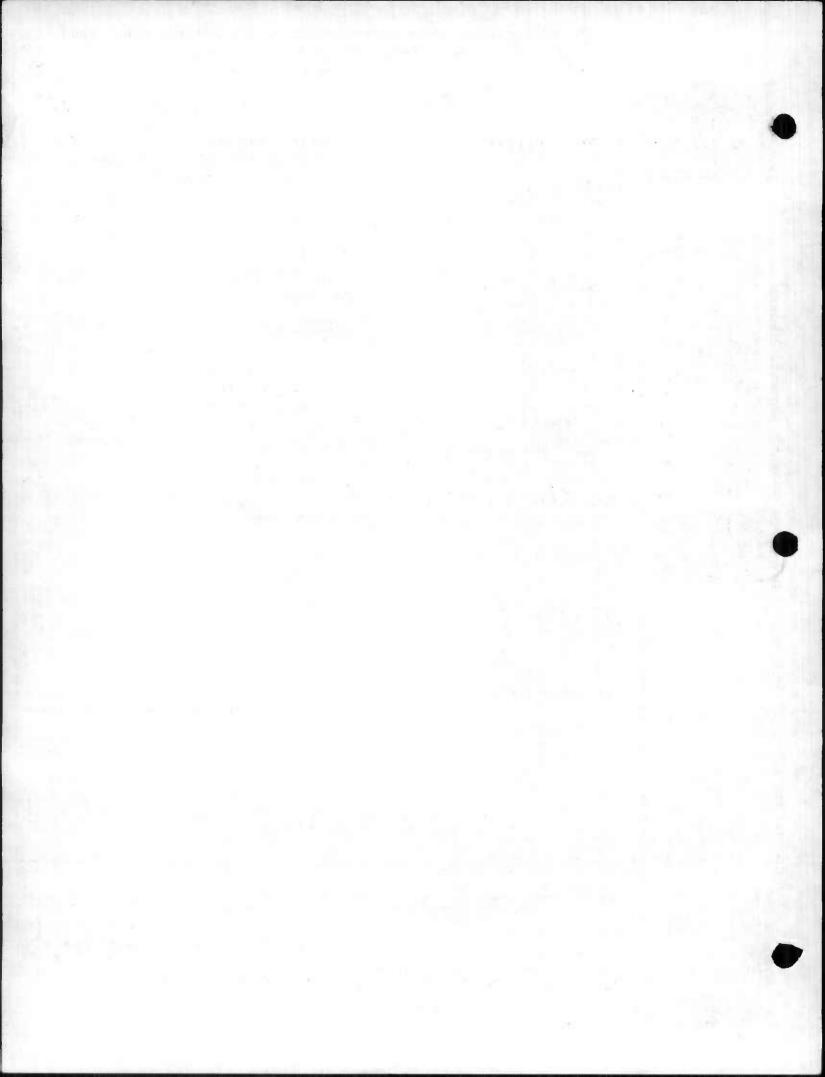
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	Item	19a	per FH Film G752 1			Cert	ificate o	f Death		Reg. No.		30/62
п	Physici	an	1. Decedent's Name (First, Middle,						2. Date of Dea Month	ath Day	Year	3. Time fth
	/Medi		Katharine F	oote M	litchel	1				2 1997		11:05am
	Examir	er	4a. Facility Name (If not institution,	give street and number	r)			4b. City, Town, or	Location of Death	4c. County	of Death	
1_			Anne Arundel					Annapol	is	Ann	e A	cundel
	Funeral Director		213-54-6352	5. Sex 7. A 1  M 2 <b>X</b> F	kge (In yrs. last b	Yrs.	If Under 1 Yes Months Day		8. Date of Birt (Month, Pa April	2 191	9. Birth	place (State or Foreign intry) Carolina
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loca	ation					10d. Inside City Limits
	f show	٥		Arundel	Riv		2001					1 ☐ Yes 2 No
	the Mar 28a-f si	rect	10e. Street end Number	ar anacr			10f. Zip Code			10g. Citizen of	What Cou	into/?
	th with	Ö	255 Bayshire	Court			211			U.S.		
0	8 85	Funeral Director	11. Merital Status  1 Never Married 2 Married	12. Was Deceden	?		as Decedent o Yes, specify Co	f Hispanic Origin? (Suben, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Rac		ican Indian, , etc.
5-0020	72 hours efter neturel", or He	b	3 ₩ Widowed 4 Divorced	If Yes, Give Yeer or Detes	:	11	□Yes 21© N	lo Specify:		Specif		ite
5-0		Completed	15. Decedent's (Specify only highest	Education grade completed)	16	a. Decede	nt's Usual Occ	cupation	rkina	16b. Kind of B	usiness/l	ndustry
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Ma	2 4 5 5		REGINALD Mitch			_		eet and Number or Ru				
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=	permit. Pegas Department of Important: If I any Injury or once.		21. Signature of Funeral Service Li		WIII	-		dress of Fecility	10/7/97	Arili	igto	on, va
Ä	Per Per Per Per Per Per Per Per Per Per		Ihomosk !	bondist	11	На	rdest	v Funera	1 Home	P.A.,	12	Ridgely
V			23a. Pert1. Enter the disease, or c shock, or heart failure. List of	omplications that cause on each	d the death. Do	not enter	the mode of d	lying, such as cardia	or respiretory en	rest.		Approximate Interval Between
	Physician										i	Onset and Death
1	'Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	· My	10 Cara	lual	mta	rction				/ day
		-		/	Due to (or as a	consequ	ence of)					/
	ited nsit	Examiner		b			1				<u> </u>	
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	e daeth car tha attandir hed for use	by Physician/	Part II. Other significant condition	contributing to death	but not resulting	In the und	lerlying ceuse	given in Part i.	23b. Did 1	obacco uee co	ntributa	to the cause of death?
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On C	ling P	Certification:	27. Manner of Deeth 1 ☑Naturel 5 ☐ Pending	28e. Dete of inj (Month, D	ay Year) 28b.	Time of Injury	28c. in W		28d. Describe I	now Injury occur	red	
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.≥	or A efter Direct in by	ET I	4 ☐ Homicide determin	building, e	njury - At home, f etc. <i>(Specify)</i>	arm, stree	it, ractory, onic		City or Tow		or or nu	al noble redition,
	apital ours heral filled		29a, Certifier 1 CertifyIng	Physician: To the best	t of my knowledg	e deeth o	occurred at the	time date and place	and due to the	rause(s) and m	enner as	steted
	Hoo 24 h Fur lately	edical	(Check only 2 Medical Ex	aminar: On the besis of manners	of examination a	nd/or inve	stigation, in my	y opinion, death occu	rred at the time,	dete and place,	and due	to the cause(s)
	To the Hospital or Attending Physician: Tha law within 24 hours effer death.  To the Funeral Director: After this cartificata has complately filled in by the funeral director, page 2	Me	29b. Signature end title of certifier	007			29c. Lice	nse number		29d. Date signe	d (Month	, Day, Year)
	1		) ( Lead )	N'Kan	100		7	0597	8	Octob	010	2,1997
,	(0)		30. Name end address of person wi	no completed cause of	death (item 23a)	) (Type, Pi	rint)	0002			7	1,,,,,
1	10)		Charles W.	Kinzer	MD.	20	03 M	edien Ph	wy #10	O. Ann	AD0	is, MD
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	rar's Signature					/		
	Registr	ar	1 0 1997	guna Loud	son-Handa	22						



State of Maryland / Department of Health and Mental Hygiene 97 30763

				Certifica	ate of	Death		Re	g. No.		00,00
Dhualaia		1. Decedant's Name (First, Middla, Las	1)	)			2.	Dete of Death Month	Dey	Year	3. Time of Death
Physiciar /Medica		HATTIE	NELSO	$\sim$			0	CTOBE	R8	1997	0755
Examine	-	4e. Facility Name (If not Institution, give NORTHWEST H	ostreet end number)					Toww	4c. County	of Death	MORE
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. les	t birthday) If Und	lar 1 Yaar	if Undar 2	24 Hrs. 8.	Date of Birth (Month, Day,			lece (Stata or Foreig
Director	-	216 -16-3498 1 Usuel Rasidence of Decedant	OM 2)QF 74	Yrs.	s Deys	Hours	Willi.	1-24-1	1923	Coun	N.C
a-f show (Sed at	tor	10a. Stata 10b. County  Md N		Fimore						10	Od. Insida City Limit
3s or 28	Direc	10e. Street and Number 2918 Ulman	Andrea		Zip Coda 2/2	45		10	g. Citizen of t	What Coun	try?
	y Funeral Director	11. Maritel Stetus  1  Never Merried 2 Married	12. Wes Decedent Ever in U.S. Armed Forcas?  1 ☐ Yes 2 ☐ No If Yas, Giva				gin? (Specif , Puarto Ric	y Yes or No- an, atc.)		e - Amaric ck, Whita, i	
ural',	D D	3 ☐ Widowed 4 ☐ Divorced	Yaar or Datas:							Da	
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m 27 is m 27 is her trax		Herman Nels	on -Son	29/8 ( e of Disposition (A	Uma	in A	henu	e Ba	140, M	d Z	1215
unt: If Na uny or of		20a. Mathod of Disposition  1 Burlai 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Ramoval from Stata	atary, crematory o	othar plac	xe) yeter			oc. Location - Baltin	-	1
Imports any inje		21. Signatura of Funarai Service Licen				ss of Fecility	1	4	10	,	2121
	-	23a. Part1. Enter the disease, or companock, or heart failure. List only	olications that caused the death.	Do not antar the m	ode of dyin	OO ng, such as o	cardiac or re	aspiratory arre	st.	12 K	Approximate
ysician ledical aminer		immediate Causa (Final disease or condition resulting in death)	SEPSIS	5						1	Interval Between Onsat and Death
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physician and stransit stransit	edical Examiner	Sequantially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disease or injury	Dua to (or es	s e consaquance o	f):						
	Medica	rasulting In death) Last	Dua to (or as	a consaquance o	):					i	
ed for us	lan	Part II. Other significant conditions co	ntributing to death but not resulting	ng in the underlying	causa giv	an in Part I.		23b. Did tob	acco use co	ntribute to	the cause of death
detach	Dy Pny	CVA						1 □ Ye	8 2□No	3 □ Prob	pably 4 20nknow
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page 2	E							1 🗆 Ya	2 ZPNo	1	Yes 2040
ertific ector,		25. Was casa rafarred to medical axaminer?					of Death (C	Check only ona	)		
his or	0	1 Yes 2 No		/Outpatient 3□		4 LI NUI		5 Resider			1)
To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Re Communication to Re-Communication t	27. Mannar of Death 28s. Dáta of Injury 28b. Tima of injury at Work? 2 Accident invastigation 3 Sulcida 8 Could not be							28d. Dascribe how injury occurred			
Direct d in by	Serum A	3 Sulcida 8 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	ı, farm, straat, fact	ory, office		281	Location (Streetly or Town,		per or Rura	l Routa Number,
Personal Fills Fil		29a. Cartifier (Check only one)  Certifying Phy 2 Medicat Exam	raicien: To the best of my knowle iner: On the basis of examination and manner stated.	dga, daath occurre and/or invastigation	od at the tin	na, data and pinion, deat	d place, end th occurred	I due to the car at the time, de	usa(s) and mo ta end place,	annar as st and dua to	ated. tha causa(s)
ompl ompl	29a. Cartifler (Check only one)  29b. Signetura and titla of certifier  29c. License number  29c. License number  29c. License number  29c. License number  30. Nama and addrass of person who complated causa of daath (item 23a) (Type, Print)  CAV MO, NHC, BAUT MORE  31. Data filed (Month) (Mont							29	d. Dete signe	d (Month, I	Dey, Year)
		De . Non	2 ly		D'	373	777	0	CTOBE	R8	1997
10/		30. Nama and address of person who o	omplated causa of daath (Item 23	Ba) (Type, Print)	ma	RE	Mo	211	33		
State		21 Date Stad Manual O. Tyrad	007 32. Registrar Signature	1 . 50 .	40	, -0			-		
Registrar	-	20, 10	997 32. Hegistar Significant	idson-Nanda	182						



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 30764 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 1997 9:45 P.M. MAILLIN 0078 B2R 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Deeth HOSPITALOH If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, H93206 72 BALTIMORE If Under 1 Months 6. Sex 9. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 08 M 2□ F Yrs. 203 22 6127 AUG-1, 1931 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE MARYLAND GLEN ARM 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? U.S.A 129071 YZARLUL VALLEY KOAC 2105 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 25 Married Specify: WHITE 1 ☐ Yes 258 No 3 ☐ Widowed 4 ☐ Divorcad 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PARS. 127RS. 230100 A.T.+T 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) NEIZAW OHOL GOLDA SVARS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JARY E. O'ROURKE 13907 DULANZY VALLEY (COAD 20c. Location - City or Town, Stete 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) CCT- Dete 15 Burial 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) DULANTYVAUEN LMORIAL 1000 Timonium, MARYLAND 22. Name and Address of Facility
EVANS CHARLE OF CHIME
2325 YORK ROAD - TIMONUM 21. Signature of Funerel Service Licensee don 1ARYLAND 23a. Pert1. Enter the disease, or complications shock, or heart feilure. List only one ceus st a caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) mos Due to (or es e consequence of): Due to (or es e consequence of) Due to (or es e consequence of) Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobagto use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown artery Listan 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy 250 No 1 Yes 1 Yes 2 No 25. Wes case referred to medical exeminer?

**Physician** /Medical Examine

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the

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signed l

page 2 s

Be

Certification: To

cal

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, I

24 hours a

To the Hospi within 24 hou To the Funer completely fil

that the death certificete be executed

Box 68760.

P.O.

Records.

Division of Vital

Department of Heelth er Important: If Rem 27 Is any Injury or other trainings.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Herms

6

natural',

should be filed within 7; nd Mental Hygiene.

h end Mental I

Pages 1 and 2 should be

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

traumatic event, the Medical Examiner must be notified at

Examiner Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Physician/Medical þ Completed

1 Yes 2 No

27. Manner of Deeth

1 Neturel

2 Accident

3 Sulcide

4 Homicide

29b. Signature and title of

Hospital:

150 Inpatient

28e. Dete of Injury (Month, Dey Year)

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e, Certifier (Check only one)

† Cartifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) end menner stated. 29d. Dete signed (Month, Dey, Year)

D 33624

2 ER/Outpatient 3 DOA

28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Houson MO. 21204

person who completed cause of deeth (Item 23e) (Type, Print) 30. Neme end eddress

7505 OSLER ORIVE SUITE 504 Downs 1 DR. 0

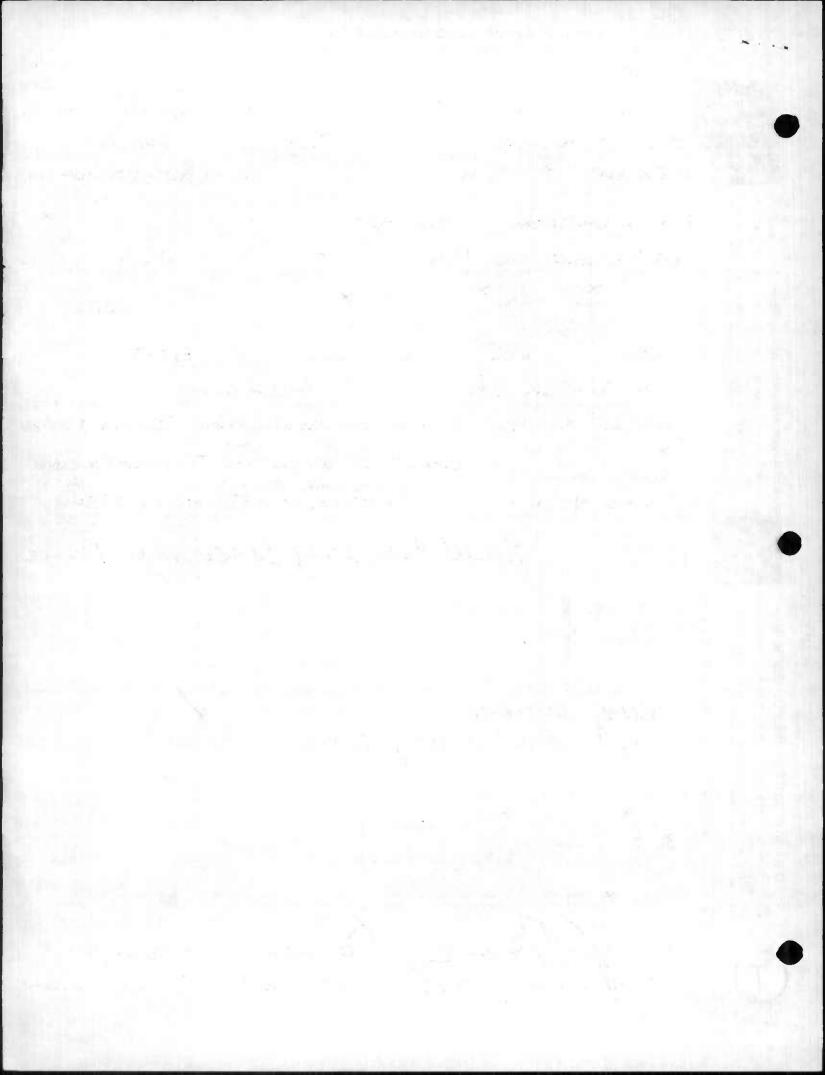
31. Dete filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined

32 Registrer's Signeture Julia Savidson

State Registrar



ealth and Mental Hygiene 97 30755

B.K.S	State of Maryland / Department of He
PATRICIA ANN PINK	Certificate of I

F	PATRICIA	A	ANN PINK				Cer	tificate of	Death		Reg. No.	0 1	00100	
			1. Decedent's Name (First, Mid	dle, Last)					1000	2. Date of Dea	ath		3. Tima of Death	
	Physici		PATRICIA A	NN PTN	JK					Month OCT.	6. 199	Yaar 7	0730 AM	
	/Medio Examin		4a. Facility Nama (If not Institut EASTON MEMO	on, give stree	et end numba				4b. City, Town, or L EASTON		4c. Count	y of Death	0)30 AM	
	Funeral Director		5. Social Security Number 216-38-8528	6. Sex 1 □ M		Age (In yrs. les	t birthday) Yrs.	If Under 1 Yaa Months Days		8. Date of Birth (Month, De)	/, Year)			
-	b		Usual Residence of Decedent							Mar 9,	1940	Mary	Tand	
	show	_	10a. State 10b. Coun	ty		10c. City,	Town or Loc	ation					10d. Inside City Limits	
	the Marylar 28a-f show	Director		York			Yor						1 ☐ Yes 2 XNo	
	with the		10e. Street and Number					10f. Zip Code				g. Citizen of What Country?		
	s 23a	eral	207 Bentwood		Man Danida	- F i - 11 C	17404  Ever in U.S. 13. Was Dacedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue			- 7 V - N		USA	and tadion	
21215-0020	72 hours efter death with the Maryland natural", or items 23a or 28e-f show	by Funeral	11. Marital Status  1 □ Never Married 2 □ Mi 3 □ Widowed 4 【XDivorce	arried 1	Armed Forces  The Yes 2X  Yes, Give  Year or Datas	s? ] No		Yes, specify Cu		Rican, etc.)	Speci	ack, White,	can indian, , etc. hite	
5-0	n 72 hours "natural",	Completed	15. Deced (Specify only high	ent's Education	n mnleted)		16a. Decedent's Usual Occupation (Give kind of work done during most of w			kina	16b. Kind of E	Business/In	idustry	
21	d within jiene. r than "	npie		Elementary/Secondery (0-12) Colle		r 5+)	life. D	O NOT use retir	red)	wing.				
	e filed w Il Hygier other th		47 E-N - d- Nove (F) - 4 44 4		4 yrs		Schoo	ol Teach					lucation	
Maryland	ed ob	To Be	17. Fathar's Nama (First, Middl						18. Mother's Nam	ie (First, Middla,	Meiden Sume	me)		
Z	d 2 should h and Mer 7 Is marke traumatic		Clifford R  19a. Informant's Name/Relatio				10h Mailin	- Address /Ctros	Elizab			Robbi		
Ma					· mu)								) Coda)	
re,	The He		David R. Sieg 20a. Method of Disposition	ez		20b. Plac	L/L3	Stanton ition (Neme of etory or other pl	Street,	PA 17404 20c. Location - City or Town, State				
OH.	@ O - \		1 Burial 2 Cremation 4 Donetion 5 Other		val from Stat	0		emetery		10/10/9	7 West	Manch	nester, PA	
Baltimore,	그는민준		21. Signature of Funeral Service			DIII.	-	Name and Add		10/10/2	West	rianci	lester, TA	
ä	Depar Impo		Martin	Was.			I	Mitchell	L-Wiedefel	d Home				
	100		23a. Part1. Enter the disease, shock, or heart failure. Li	or complication	ons that cause	ed the death.	Do not ente	500 Yor r the mode of dy	ck Road, B ying, such es cardiac	altimor	e, Mary	land	21212 Approximete	
	Physician		snock, or heart failure. Li	st only ona ca	luse on each	line.							interval Between Onset and Death	
	/Medicai		Immadiate Cause (Final disease or condition			Mu	1AA	le I	Ljune	(		1		
и	Examiner		resulting In death)	a		Due to (or a			7	7				
-	D #	ine		<b>a</b> b										
	and and II-transit	Examiner	Sequentially list conditions,			Due to (or a	s a consequ	ience of):						
60,	be exercian a		if any, leading to Immadiate ceuse. Enter Underlying Cause (Disease or injury	C	-							Ī		
68760,	hys the	Medical	that initiated events resulting in death) Last	1		Due to (or as	s a consequ	ence of):				t		
×	eth certific ettending p			d										
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0	t + 6	hys	Part II. Other significent condi	IONA CONTIDU	ling to death	but not resulti	ng in the un	denying ceuse g	given in Part I.	1 1	A.		to the causs of death?	
В, Р	the page	by P										00,110	, v , v , v , v , v , v , v , v , v , v	
Records,	v requires been sign should be										an autopsy med?	24b. W	Pere eutopsy findings	
900	aw Is b	Completed								porto		CC	ompletion of cause death?	
Ä	The la	mo.								152	'es 2□No	2	Yes 2□ No	
Vital		Be	25. Was case referred to medic examiner?	al					26. Place of Dee	th (Check only o	ne)		.)	
of V	Physiclan: this certific ral director,	To	XX Yes 2□ No	Hospi	tal: 1 🗆 Inpai	tiant XXEF	VOutpatient	3□ DOA O	ther: 4 Nursing Ho	ome 5 Resid	lence 6 🗆 Ot	her (Speci	(hy)	
n o			27, Manner of Death 1 □ Netural 5 □ Pend	ling 28	Ba. Date of In (Month, D	jury 28 ay Year)	Bb. Tima of Injury	28c. Inju	ury at ork?	28d. Describe h	ow Injury occu	rred	, , ,	
Sio	Attanding or death. actor: After by the fune	catl		tigation	10/6/	97 0	730	M 1[	Yes 20 No	priver	inau	400	ecident	
Division	after death after death Diractor:	Certification:		mined 28	Be. Place of Ir building, e	njury - At home etc. (Specify)	e, farm, stre	et, factory, office	9	City or Tou	m, Stete)	ber or Run	al Route Number,	
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	Hos 24 hc Fun etely	edical	the state of the s	i Examiner:		of exemination			time, date and place, opinion, death occur					
	To the Hospital or I within 24 hours affer To the Funeral Dirac completely filled in E	Me	29b. Signature and title of certif	-		. ^		29c. Licer	nse number		29d. Date sign	ed (Month,	Dey, Year)	
	or To		W.V.		10	au)		0.0	C.M.E		OCT.	7, 1	997	
	0.00		1 (000	(1)	21	- MARKET								

State Registrar

111 Penn Street, Baltimore, Maryland 21201

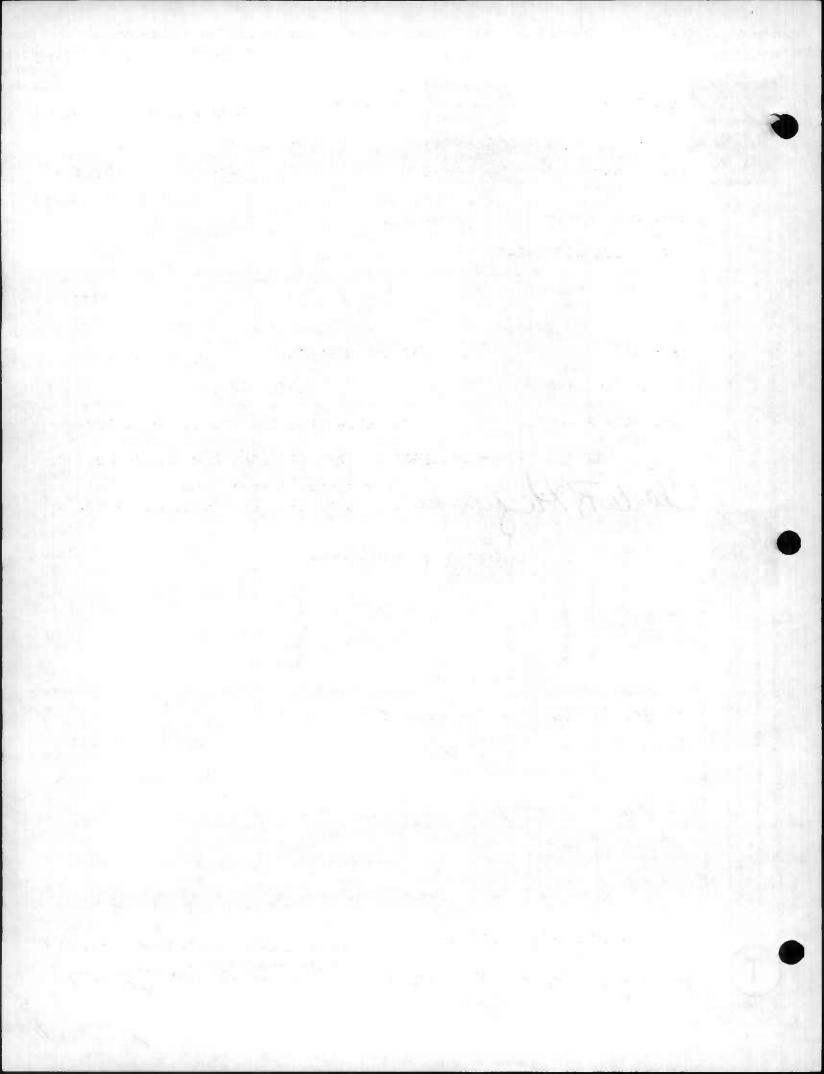
Refer to the second of the second of Shanlard List and

State of Maryland / Department of Health and Mental Hygiene 97 30766

					Cei	tificate	of.	Death	Re	g. No.				
Physici /Medic		1. Decedent's Neme (First, Middle, Le Richard		Pe	rout	k	2	2. Dete of Deet Month OCTOBER	Dey Yeer		3. Time of Death 4:45 P			
Examin							b. City, Town, or Lo		4c. County		7.72 1			
Funeral Director				Age (In yrs. les	st birthday) 9 Yrs.	if Under 1 Months		ALTIMORE if Undar 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, 7-26-3		9. Birthpiece (State or Forai MARYL AND			
		Usual Residence of Decedent		1.0 00										
show	7	10a. Stete 10b. County		10c. City,	NDAL I						10	d. Inside City Limits		
280-1	Directo	MARYLAND BALTO					1 Yes 2 No							
23a or	ral Dir	10e. Street and Number 7817 LOCKWOOD ROAD 21222								10g. Citizen of Whet Country?				
al', or its Examine	by Funeral	11. Marital Stetus  1 Never Married 2 Married  3 Widowed 4 Divorcad	12. Wes Dacedal Armed Forca 1 Tyes 2 If If Yas, Giva Yeer or Date:	if Yes, specify Cuben, Maxice  ☐ Yas 2 ☑ No Specify  1 ☐ Yas 2 ☑ No Specify		lispenic Origin? (Sp en, Maxicen, Puerto Specify:	ecify Yes or No- Ricen, atc.)	Ble	14. Rece - American Indien, Bleck, Whita, atc. Specify: WHITE					
e di	eted	15. Decedent's E (Specify only highest gre	ducation		(Give	lent's Usuei	done	during most of work	ina	18b. Kind of B	usiness/Indi	ustry		
than	Completed	Eiamentary/Secondary (0-12) Coilega (1-4or 5+)				INE 0	retired	1)		JOHN D. LUCAS				
other ont,	Be C	17. Fathar's Nama (First, Middle, Last	)						eme (First, Middle, Meiden Surname)					
f Health end Mental Hygi Item 27 Is marked other other traumatic event, it	To B	FRANK PEROUTKA	A					ELSIE V	ANDIVE	R				
le mai		19e. informent's Name/Reletionship (	Type, Print)	W	19b. Mailir	g Addrass (	Street	end Number or Run	al Route Number,	City or Town	Steta, Zip (	Code)		
Health e em 27 ls ther trai		MRS. MARY PEROL	JTKA	. 1	781	7 LOC	KWI	OOD ROAD	BALTO	. MD.	2122	22		
nent of Health nt: If Item 27 iry or other to		MRS. MARY PEROUTKA  7817 LOCKWOOD ROAD BALTO. MD. 21222  20e. Mathod of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Entombril entSACRED HEART OF JESUS CEM BALTO. CO. MD.												
Department of Important of Important of Important If I any Injury or a many	23a. Pert1. Enter the disease, or comshock, or haart failure. List only immediate Causa (Final disease or condition resulting in daeth)	desau		Do not ente	201 D or the mode	OW: UNI of dyin	SKI FUNE DALK AVE 19, such es cardiac	BALT	OMD		Approximeta Intervel Between Onset and Deeth			
es been signed by the attending physician and a 2 should be deteched for use es the burial-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Ceusa (Disasse or injury thet initieted events resulting in deeth) Last	b											
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e attend	sicia	Per il. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  Systemic Cypus erythematosis  Ever of unknown origin						en in Pert I.	23b. Did to	bacco use co	ntribute to	the cause of death?		
signed by the d be deteched	y Physician								1 🗆 Ye		3 Prob			
hes been sig	Completed by	fever of unki	rown c	origin	1				24e. Wes ar perform	n eutopsy nad?	evai	re eutopsy findings ilable prior to npietion of cause eath?		
pag									12 Ye	s 2 No	10	Yes 2 No		
is certificate he director, page	Be	25. Wes case rafarrad to medical axaminer?	Hospitei:				Oth	28. Piaca of Deat	h (Check only on	9)				
五 西	ition: To	1 Yas 2 No  27. Mannar of Daath 1 Naturei 5 Pending 2 Accidant investigation	4 LI Nursing no	Home 5 ☐ Residence 8 ☐ Other (Specify)  28d. Describe how injury occurred										
within 24 hours effer death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accidant investigation 3 Sulcide 6 Could not be determined 28e. Pleca of injury - At home, ferm, street, fectory, offica building, atc. (Specify)							28f. Location (Streat and Number or Rural Route Number, City or Town, State)					
within 24 hours effer d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Ph	yeician: To the bes niner: On the basis end mennar	of examination	dga, deeth n end/or inv	occurred at restigation, In	the tin	na, date end pieca, pinion, deeth occuri	end due to tha ca red at the time, da	use(s) and mate and piace,	enner es ste and dua to	eted. tha ceuse(s)		
Toth	M	29b. Signatura and title of committee	end	I.D.		29c. I	icens	e number	25	od. Dete signe Octobe	^	) 1997		
(1)		30. Name and addrass of person who	complated cause of	daeth (Itam 2:		Print) L'AST	Los	pital, B	altimo	M. MI	212	87		

Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

97 30767

	) Di	er MD G-752 10/10/97	dh		Ce	runca	te of	Death		Re	g. No.				
		1. Decedent's Name (First, Middle, L.	ast)	10					2. Det Mo	e of Death	Day	Vans	3. Time of	Death	
Physicia /Medic		James Donal	d Paulus	3					Sep		1, 19	97	4:25	PM	
Examin		4a. Facility Name (If not institution, gi	llity Name (If not institution, give street end number)					4b. City, Town,	or Location	of Death	alh 4c. County of De				
		216 Fallsbrook	Road					Timo	nium	ium Baltimore					
Funeral			Sex 7. Age	(in yrs. les	s. lest birthday) If Under 1 Year   If Under 24 H				Hrs. 8. Dat	e of Birth	Year	9. Birthp Coun	laca (Stete o	r Foreig	
Director		212-20-7328	1\\\ M 2□F	71	Yrs.	IVIOLITATIO	Doys	Tiodis	Oct	30,	1925		land		
23a or 28a-f show		Usual Residence of Decedent		10. 04.											
	_	10a. State 10b. County		10c. City,								,	0d. Inside Ci		
Na-1	cto	Maryland Baltimore Timonium												ZMIN	
or 2	Director	10e. Street and Number				10f. ZI	p Code			10	og. Citizen of		itry?		
or Items 23	- E	216 Fallsbrook		21093							USA				
	Funeral	11. Marital Stetus	Armed Forces?	2. Was Decedent Ever in U,S. 13. Wes De If Yes, s			dent of ecity Cub	Hispenic Origin en, Mexican, P	? (Specify Ye uerto Rican,	s or No- etc.)	No- 14. Race - American Indien, Bieck, White, etc.				
		1 Never Married 2 Married	1 V Yes 2 □ N If Yes, Give	0		1□ Yes	2 🕅 No	Specify:			Specif	<i>y</i> :			
Ex	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1944			**					Whi			
"naturel", adipsi Ex	Completed	15. Decedent's E (Specify only highest g		16e. Decedent's Usual Occupation (Give kind of work done during most of working)  16b. Kind of Busin							Jusiness/Ind	dustry			
than "	du	Elementery/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT use retired)										
al Hygie cother t vent, tr	ပိ	12 17. Fether's Name (First, Middle, Las	4	4 Senior P			18. Mother's Name (First, Midd				Mechanical Engi			er.	
Mental Farked ot	Be		•												
nd Menta marked imatic ev	5	Joseph Matthi					- 10	Ida		Elizabeth		oller			
is m		19a. Intormant's Name/Reletionship						t end Number o					Code)		
f Health and Mental Hyg tem 27 is marked other other traummtic event,	-	Lovelyn Britva	ar/Daughter			osition (Ne		Woody	-				Ctoto		
2		20e. Method of Disposition 1 □XBuriel 2 □ Cremation 3 i	☐Removal trom State	cen	netery, cre	emetory or	other pie	•	Date		20c. Location	- City or 10	wn, State		
ant:		4 □ Donation 5 □ Other (Spec	ify)	Vet	erans	s-Gar	riso	n Fores	t 9/26	5/97	Garri	son,	Mary1	and	
Department Important: If any injury or once.		21. Signature of Funeral Service Liq	22. Name and Address of Facility  Lemmon Funeral Home												
. A E & 8		Bryan W. Ch	yary)							rimon.	film M	D 21	093		
		By an W. Lay  10 W. Padonia Road, Timonium, MD  23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and or heart allure. List only one cause on each line.											Approximat	6	
nysician		shoot, or mean failure. List only	y one cause on each line	ð.								1	Onset and		
/Medical		immediate cone (Final disease or condition resulting in death)  a. CARQUE ARREST  Due to (or es a consequence of):									1	MINU	TES		
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nd ransi	Examiner	Sequentially list conditions  b. CORONARY ARTERY DI SEASE  Due to (or as a consequence ot):													
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ling physician and e as the burial-tran	2	resulting In death) Lest										1			
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e ettend ed for us	Cla	Part il. Other significant conditions	contributing to death bu	t not result	ing In the	underlying	ceuse a	ven in Pert I	23	3b. Did to	bacco usa co	ontribute to	the causa	of deaf	
oy the	Physician	Part II. Other elgnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.						-	23b. Did tobacco usa contribute to the causa of ded  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown						
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per e	.0									24a. Was an autopsy 24b. Were autop			ere autopsy	finding	
5 2	D									perform	ned?	CO	ailable prior i mpletion of death?		
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hes been s je 2 should	mpleted											1 L	Yes 2	140	
ate hes been s page 2 should	Completed									1 ☐ Ye	s 2 No				
ate hes been s page 2 should	Be Completed	25. Was case reterred to medical exeminer?	Hoenital					hor	Death (Chec	ck only on	e)				
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certificate hes been s'ector, page 2 should	To Be Completed	exeminer?  1 Yes 2 No  27. Manner of Deeth 1 Whatural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  1 Yes 2 No 5 Pending Investigati 6 Could not determine	28a. Date of Injunon be de 28e. Place of Injunbuilding, etc. thysician: To the best of iminer: On the basis of iminer.	ry - At hom (Specify)	Injury ie, farm, s edge, dea	of M treet, tacto	28c. Inju	iny at ork?  Yes 2 No	28d. De 28f. Loc	Aeside escribe ho cation (Stry or Town	e)  nnce 6 □Ott  www.injury.occu  reet end Num  n, Stete)  suss(s) and m	ber or Rura	il Route Nun		
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 30768

		Certificate of Death Reg. No.											
Physici /Medi		1. Decedent's Nema (First, Middle, Last)  2. Data of Death  CATHERINE ANNA PENN  2. Data of Death  OCTUBER Day  1. 199									3. Tima of Death 2:48 Pt		
Examir		4a. Facility Nama (II not institution, gir Saint Joseph	Medical	Cent	ter		4b. City, Town, o	r Location of Deet 5 O N	h 4c. Count	y of Death Balt	imore		
Funeral Director			Sax 7. A 1 □ M 2 3 F	ga (In yrs.	(ast birthday) Yrs.	If Under 1 \ Months C	Year If Under 24 Hr lays Hours Min	n. (Month, De	Data of Birth Month, Day, Year)  B 2, 1926  9. Birthplaca (Stata or Fore Country)  Moryland				
aryland show	-	10a. Stata 10b. County			y, Town or Loc	ation				1	Od. Inside City Limit		
N S N	Director	Md. Baltimore		Par	KVILLE						1 ☐ Yas 2 🔼 N		
S &	급	10e. Street and Number	<b>D</b>			10f. Zip Co		10g. Citizan of		itry?			
ath a	rai	9219 Harford VIE				_	1234		USA				
72 hours after death with the Maryland natural", or items 23a or 28s-1 show digs! Examiner must be notified at	by Funeral	11. Marital Status  1 Nevar Married 2 Married  3 Wildowed 4 Divorced	12. Was Decadant Armed Forcas 1  Yes 2 If Yas, Giva Yeer or Datas:		/as Decedan Yas, specify □ Yas 2 🕅		Specify:			White, etc.			
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within ene. than	Completed	(Specify only highast gr Elemantary/Secondary (0-12)		Collaga (1-4or 5+)			lona during most of wa atired)	orking	RETA	.11			
tal Hygie d other event, to	Bec	17. Fathar's Nama (First, Middla, Lasi	0			SALES	18. Mothar's Na	ama (First, Middla	, Maidan Sumar	ia)			
Manta Manta Marked arked	ToB	WILLIAM HESS  19a. Informant's Name/Reletionship	Type, Print)		19b Mailing	Address (S		nerine Klein  Rural Route Number, City or Town, Stata, Zi			Code)		
alth and 27 is me													
Hem 27		20a. Mathod of Disposition	nusband 20b. 1		lace of Dispos	ition (Nama	of	Date	Balto, Md. 21 20c. Location - City of				
Pages nent of I nnt: If Ite ury or o		1 ⊠ Burial 2 ☐ Cremation 3 [	Ramovel from Steta cemetery, crit				-	OCT 10					
it. P.		4 Donation 5 Other (Speci		St.			H Cemetery	1997	FULLER	1, MOT.	M		
permit. Pages Department of Important: If It any Injury or once.		21. Signeture of Funaral Sarvice Licensea  22. Name and Address of Facility  EVALS Charge of Memories 8800 Harford Rd Botto. N  23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, interval Botto N  Approximate Interval Botto N  Onset and											
Physician /Medical		23a. Part1. Enter the disease, or cort shock, or heart failure. List only Immediate Causa (Final					f dying, such as cardio				Approximata Intarval Batween Onsat and Daath		
Examiner		disease or condition resulting in death)	a  Dua to (or as a consequence of):										
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icate be axecuted physician and s the buriat-transit	Examiner	Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	D	Dua to (or as a consequance of):									
D' B	Medical	that initiated events rasulting in death) Last	d	Due to (or es e consequance of):									
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tha de	Completed by Physician/	Part II. Other significant conditions	contributing to death i								tobacco usa contribute to the cause of deat		
that bed b								1 🗆	Yes 2□ No	3 □ Prot	bably 4 Vunkno		
2 00 CM									an autopsy ormed?	ave	ara autopsy findings aliabla prior to mplation of ceuse daath?		
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Physician: this certific ral director,	To	axaminar? 1 ☐ Yes 💥 No	Hospital:	ient 20	ER/Outpatient	3□ DOA	Othar: 4 Nursing	Homa 5 ☐ Rasi	dance 6 □Oth	nar (Specifi	v)		
Attending Physic death. sctor: After this by the funeral di		27. Mannar of Daath  12 Natural 5 Panding 2 Accident Investigatio	28a. Data of Inji (Month, Da	8a. Data of Injury (Month, Day Year) 28b.			Injury at Work?		28d. Dascribe how injury occurred				
마 분 보 드	Certification:	3 Suicide 6 Could not be datarmined	28a. Place of in	jury - At ho tc. (Spacify	ma, farm, stree	et, factory, of	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)						
To the Hospital within 24 hours a To the Funeral C completely filled	edical	29a. Cartifiar K Certifying Ph (Check only one) 2 Medicat Example (Check only one)	nysician: To the best niner: On the besis of and manner si	of axaminat	wledga, daath o ion and/or Inva	occurred at the stigation, in	na tima, data and place my opinion, daath occ	ce, and dua to tha curred at tha tima,	causa(s) and m data and place,	annar as st and dua to	ated. tha ceusa(s)		
vithin o th	Me e	29b. Signatura and titla of certifiar				29c. L	censa number		29d. Data signe	ed (Month,	Day, Year)		
- s - ō		By H. Kal	Lus.				8662			16/97			
	30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) BRIAN H. KAHN, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204												
Sta	-	31. Data filed (Month, Day, Yaar)	32 Regist	cas's Signal	- Randel	2							

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State of Maryland / Department of Health and Mental Hygiene 97

					Cei	rtificate of	Death			Reg. No.															
Discordados.	_	1. Decedent's Name (First, Middle, La	ist)			10.			2. Date of De	eath Day	Voor	3. Time of Death													
Physician /Medicai		MARY E. PEEPLES							Septe	mber 19	, 1997	18:30													
Examiner	-	4a. Facility Name (If not institution, give street and number)					4b. City, To	wn, or Lo	ocation of Deat																
	ı	The Johns Hopkin	ns Hospit	al			Balti	more	9		N/A														
Funerai	1		Sex 7.7	Age (In yrs. las		If Under 1 Year Months Days		24 Hrs. Min,	8. Date of Bir (Month, Da	th v. Year)	9. Birthp	laca (State or Foreign													
Director .	1	220-12-9214	10 M 284	73	Yrs.				April	6,1924	Mar	y1and													
3_	-	Usuai Residenca of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation					1	0d. Inside City Limits													
natural, or items 23a or 28a-4 show sical Examiner must be notified at the driver of t		Maryland N/A	A		ltim							Yes 2 No													
or 2		10e. Street end Number				10f. Zip Code				10g. Citizen of Whet Country?															
23.8		3139 Keswick Roa	ad				21211			US	SA														
r items 23anber munt		11. Marital Status	12. Was Deceder Armed Forces	5?	13.	Was Decedent of I If Yes, specify Cub	Hispanic Orlean, Mexican	gin? (Sp., Puerto	ecify Yes or No Rican, etc.)		e - Americ														
ar, or it	2	1 □ Never Married 2 □ Married 1 □ Yes 🛣 No If Yes, Give Year or Dates:				1□ Yes XXNo					ily: White														
	2	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondery (0-12) College (1-4or 5+)			16a. Dece	dent's Usual Occu	pation		2	16b. Kind of B	usiness/Inc	dustry													
ont, the Medical	2				(Give kind of work done during most of work life. DO NOT use retired)			or work	ing																
	5	11		Telephone (			erator			Bank	mation														
matic event, I		17. Father's Name (First, Middle, Last	)						e (First, Middle, Maiden Sum		ame)														
To	2	Leon Mitchell I	chell Lutz					5	Sadie M	ay Dolch	ner														
traumatic		19a. Informant's Name/Relationship (			19b. Malling Address (Street and Number																				
1 1		James Peeples	Son			3139 Kesv	wick R	oad,	Balti	more, Ma	aryla	nd 21211													
r other		1	20a. Method of Disposition  → 1X Burial 2 ☐ Cremation 3 ☐	Damausi tuan Stat	0000	e of Disponetery, crer	sition (Name of matory or other pla	ice)		Date	20c. Location	City or To	wn, State												
27		4 Donation 5 Other (Special		GC	od Sl	nepherd (	Cemete	ry	9/23	Ellicot	t Cit	ty, MD													
any Injury or once.		21. Signature of Funeral Servica Licar	nses N/			. Name and Addre			21 Home 21211																
58	Burgee-Henss Funeral Home 21211  3631 Falls Road, Baltimore, Maryland  233. Pant Empeths disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, interval onsets.  Approximately a complication of the complex of the																								
		23a. Part1. Enter the disease, or com	plications that caus	ed the death.	Do not ent	or the mode of dyl	LS_ROa	Cardiec	Saltimo: or respiretory e	re, Mary	land	Approximate													
cian	1	snock, or yeart failure. List only										Interval Between Onset and Deeth													
cal		Immediate Cause (Final disease or condition	Int	race	reh	ral h	ema	cla	000		1	14 hours													
ner		resulting in death)	a	Due to for a	s a consec	mence of):	CVIIOV	1 VI	age.																
e e			CI	1.000	3 0 0011300	1,000	. An	Thu	re			Chronic,													
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20		that initiated events resulting in death) Last	b. Chronic heart failur  Due to (or as a consequence of):  Chronic obstructive pu  Due to (or as a consequence of):						111101100	1 0013.0	1	orig seman													
use as the burial-transmission with the second seco		resulting in death) Last	d																						
Physician	sicia	Part II. Other significant conditions o	ontributing to death	but not resultin	ng In the u	nderlying cause gi	ven in Part I		23b. Did tobacco use contribute to the cause of			the cause of death?													
be deteched to by Physic									10	☐ Yes 2☐ No 3☐ Probably 4☐ Unknown															
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atlo		1 Netural 5 Pending investigation		.,	,,																				
d in by the		3 ☐ Sulcide 6 ☐ Could not be determined	286. Piece of I	njury - At home	e, farm, str	eet, factory, offica			28f. Location ( City or To	Street and Number State)	er or Rura	l Route Number,													
led in by the funera Certification:			bunding,	sto. (opecny)					0.1, 0. 10	, σ.α.σ,															
completely filled in by the funeral Medical Certification:		(Check only 2 Madical Exam	yalclan: To the bes	of examination	dge, death	occurred at the ti	me, date en	d place, th occurr	and due to the ed et the time,	cause(s) and madate and place,	enner as st and due to	ated. the cause(s)													
completely filled Medical Ce		one)	and manner s	stated.		00-11				00d Data siana	d (4 tanth	Day Mand													
0	1	29b. Signature and title of confiner				29c. Licens		0-		29d. Date signe															
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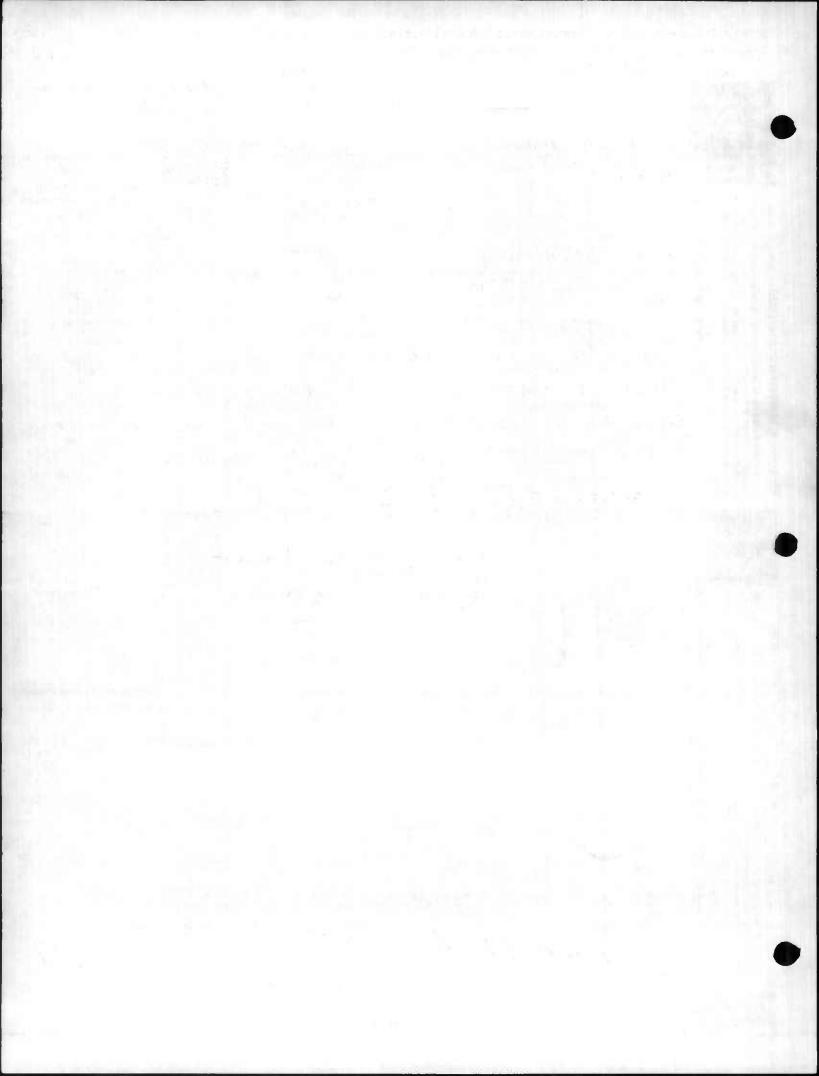


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 1 per MD G-752 10/10/97 dh 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** 00 f.m OCHOBER /Medical 4e. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGA (In yrs. last birthday) If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Alameda 9. Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number **Funeral** 1□ M 21 F 214-15-9169 92 Yrs. Director Md Usuel Rasidance of Dacedant filed within 72 hours efter death with the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho Baltimore NA Yas 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? . S.A 21239 5214 ameda Heme 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: Wes Dacedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indien, Biack, White, etc. 11. Maritel Stetus Peges 1 and 2 should be filed within 72 hours efter de nent of Heelth and Mental Hygiene. snt: If Item 27 ia marked other than "natural", or item ury or other traumatic event, the Medical Examine. 1 □ Naver Marriad 2 □ Married Baltimore, Maryland 21215-0020 1□ Yas 2 No Black Specify: Specify: 3 X Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Nursing Home Secondary (0-12) Collaga (1-4or 5+) Aide to grade NA Murses 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Sumame) Be Levinia 194. Informant's Name/Ralationship (Type, Print) 19b. Maiting Address (Straat and Numbar or Rural Routa Number, vaughter 5214 ma altimore 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cometery, crematory or other p 20c. Location - City or Town, State Buriel 2 Cramation 3 Ramoval from State permit. Pege Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Servica Licansae 21215 22. Nama end Addrass of Fecility 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw **Physician** /Medical Immediata Cause (Final diseasa or condition resulting in daath) Examiner Due to (or as a Co Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the buriel-transit Saquentially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Diseasa or trijury that hittiated evants rasulting in death) Last pue to (or as a consequence of) P.O. Box 68760. Due to (or as a consequence of): ettending pl Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown of Vital Records, þ director, page 2 should be 24b. Wara autopsy findings eveilable prior to completion of causa of daath? Be Completed 24a. Was an eutopsy performed? After this certificate has 1 Yas 2 No 1 Yas 2 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Yas 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s efter death.

ii Director: After this ed in by the funeral di 27. Manner of Daath Certification: 28b. Tima of 28c. tnjury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending Invastigation 1 Yas 2 Accidant 6 Could not be detarmined 3 Suicide 28a. Placa of injury - At homa, farm, streat, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida To the Hospital of within 24 hours er To the Funeral Drompletely filled Certifying Physician: To the bast of my knowledga, death occurred et tha tima, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. Medical (Check only one) 29b. Signatura end file of certifier 29c. Licansa number 29d. Deta signed (Month, Day, Year) RUSSEII MOTOTAN BLOGA 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) och Rowen Blvd 5601 31. Dete filed (Month, Day, Yaar) 32. Ragistrar's Signature State Julia Davidson

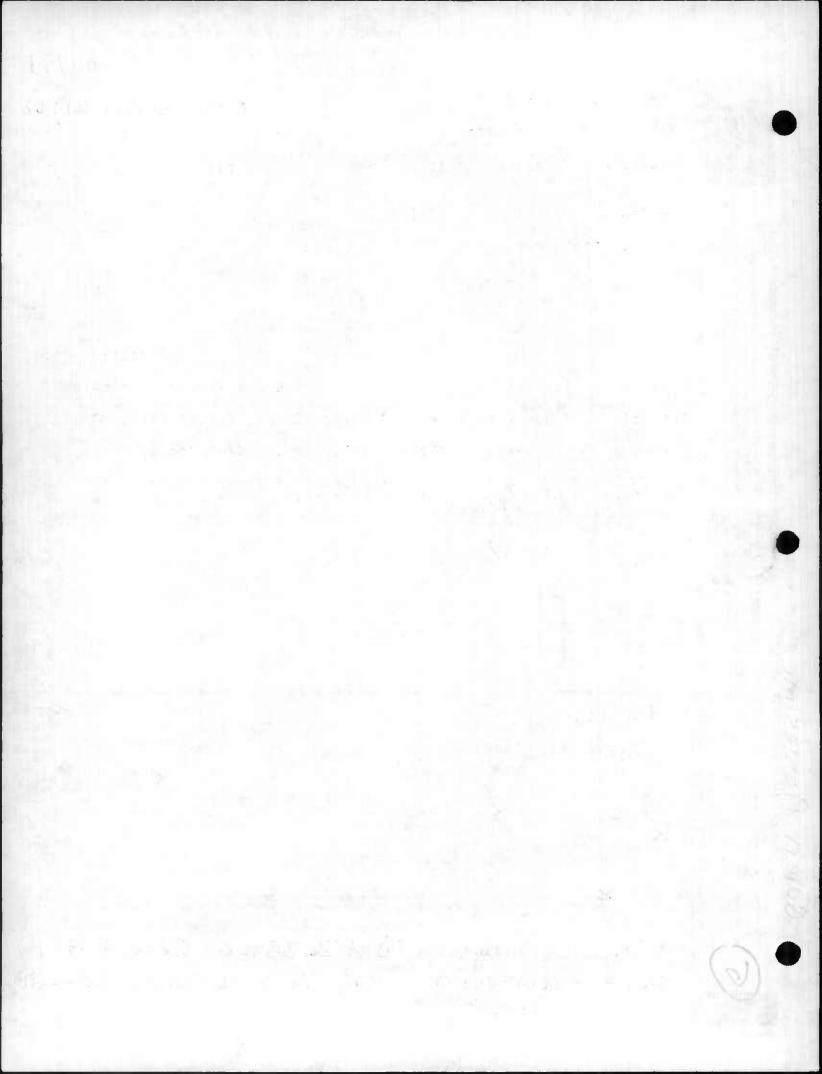
Registrar



State of Maryland / Department of Health and Mental Hygiene

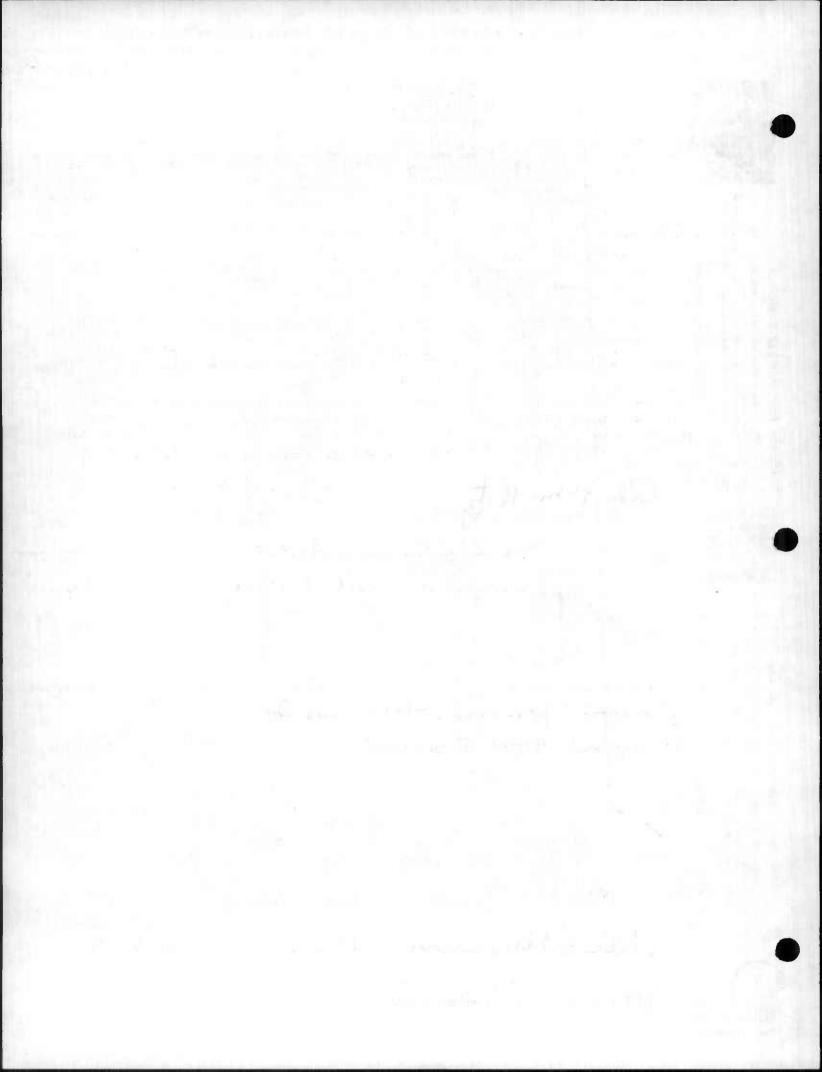
Certificate of Death 1. Decedant's Nama (First, Middle, Last)
Galen G. Picklesimer 2. Data of Daath **Physician** 21:08 Otober /Medical 4a Facility Nama (If not institution, give street and number)
Union Memorial Hospital 4b. City, Town, or Location of Daeth Baltimore 4c. County of Death Examiner Months Days Hours Min. A pril 1 year 9. Birthpiaca (Stata or pril 1 year) 9. Birthpiaca (Stata or pril 2 year) 9. Birthpiaca (Stata or Kentty ucky 5. Social Sacurity Number 289 - 05 - 8501 7. Aga (In yrs. last birthday) 84 Yrs. 9. Birthpiaca (Stata or Foraign **Funeral** 1□XM 2□ F Director Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner naut be notified at Maryland N/A Baltimore Director X Yas 2 No the 10f. Zip Coda 2 1 2 1 1 10e. Street and Number 413 W. 24th Street 10g. Citizen of What Country? 6 items 23a Funeral Was Decedant Evar in U,S. Armad Forcas? 13. Was Dacadant of Hispanic Origin? (Spacify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.)
1 ☐ Yas 2 ☐ No Specify: 14. Race - Amarican Indlen, Black, Whita, atc. White 1 Nevar Marriad 2 Married 1 ☐ Yes 2 X XIo If Yas, Giva Yaar or Dates: Baltimore, Maryland 21215-0020 "natural", or by 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 721 Department of Health and Mental Hygiene, important: if Item 27 is marked other than 'netuenty hijury or other traumatic event 15. Decedant's Education (Specify only highast grade complated) 16a. Decedant's Usuai Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11 Carpenter Contracting Co. 17. Fathar's Name (First, Middle, Lest) 18. Mothar's Nama (First, Middla, Maiden Sumame) Willie Picklesimer Lydia Margaret Trimble 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Patricia P. Ganey (Daughter) 2201 Byton Court, Forest Hill, MD 21050 20a. Method of Disposition 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stata Data Du Talley e y alotte y alotte y an . ₩ Burlal 2 Cramation 3 Removal from Stata 10/13 Cockeysville, MD 5 Other (Specify) 4 Donatlo Funaral Sarvica Line <sup>22</sup> Name and Address of Fecility Burgee-Hens's Funeral Home 3631 Falls Road, Baltimore, Maryland 23a. Part. Ental tria silla sa, or complications that caused the daath. Do not entar tha moda of dying, such as cardiac or respiratory errest, shock, or peart failura. List only one cause on each line. Approximate interval Batween Onsat and Death Physician /Medical Immediate Cause (Final moliquency unknown disaasa or condition resulting in daath) Examiner Dua to (or as a consequence of): Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseesa or Injury that initiated avants rasulting in daath) Last Due to (or as a consequence of) icklesimer Physician/Medical Dua to (or as e consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Ancites þ Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was casa raferred to madical examinar? 89 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Certification: To 1 Yas 2 No 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 27. Mangar of Death 28b. Tima of injury 28d. Dascribe how injury occurred 28c. Injury at Work? Atter 5 Panding invastigation 1 Naturai 2 Accidant 1 Tyes 2 No 6 Could not be datarmined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 - Homicida Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and dua to the cause(s) end manner as stetad.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and dua to the cause(s) and manner stated. 29a. Certifiar (Check only one) 24 To the 2 within 2 To the 9 29c. Licansa number 29b. Signatura and title of certifiar 29d. Deta signed (Month, Day, Year) AT2438946 30. Nama end addrass of person who complated causa of daalt) (Itam 23a) (Type, Print) UNION MEMORIAL HOSPITAL Boltiman MD PICCIAFUOCO SILVIA 31. Date filed (Month, Dey, Year) Lika Faridson Manathian State 1 0 1997 Registrar



State of Maryland / Department of Health and Mental Hygiene 97 30772

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Funeral		5. Social Security Number	6. Sex		(In yrs. last	birthday)	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Dete of Birth Month, Day Aug. 1.2	Yearl -	9. Birth	place (Stete or F
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and s m		19a. Informant's Name/Relation	nship (Type, Pri	int)	1	9b. Meilir	g Address	(Street	end Numbe	r or Rura	I Route Number	City or Town	, Stete, Zi	ip Code)
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within 24 hours aftar death.  To the Funeral Director: After this certificate has been signed by tha at completely filled in by the funeral director, page 2 should be detached it	edical Certification: To Be	25. Was case referred to medic examiner? 1   Yes   2   No  27. Manner of Death 1   Naturel   5   Pend inves   2   Accident   3   Suicide   4   Homicide   29a. Certifier (Check only one)	Hospital Hospital Jale Hospital Jale Hospital Jale Jale Jale Jale Jale Jale Jale Ja	l: 1 ☐ Inpatier Dete of Injur (Month, Day Place of Injur building, etc To the best of the bests of the manner star	nt 2 EP/ y Year) 28t  rry - At home. (Specify)  f my knowlecexaminetion led.	Outpetien  Time of Injury  farm, struge, death	t 3 DO	A Otto	26. Plece her: 4 Nu ry at fk?  Yes 2 1  me, date and ppinion, deat se number	no di piace, chi occurre	1 Ye  24e. Wes e perform  1 Ye  1 (Check only on me 5 Reside 28d. Describe ho  28f. Location (St. City or Town and due to the ceed et the time, de	n eutopsy ned?  ss 2 No e) unce 6 Otto w Injury occu reet and Num o, State)  susse(s) end mate end plece, ed. Date signe	3 Production of the Production	Vere eutopsy find valleble prior to ompletion of cau if death?  Yes 2 No. (ify)  Yes 2 No. (ify)  Yes 2 No. (ify)



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.

IMAME KNOWN TO PHYSICIAN.

TO PHYSICIAN TO PHYSICIAN.

TO PHYSICIAN TO PHYSICIAN.

TO PHYSICIAN TO PHYSICIAN.

TO PHYSICIAN TO PHYSICIAN.

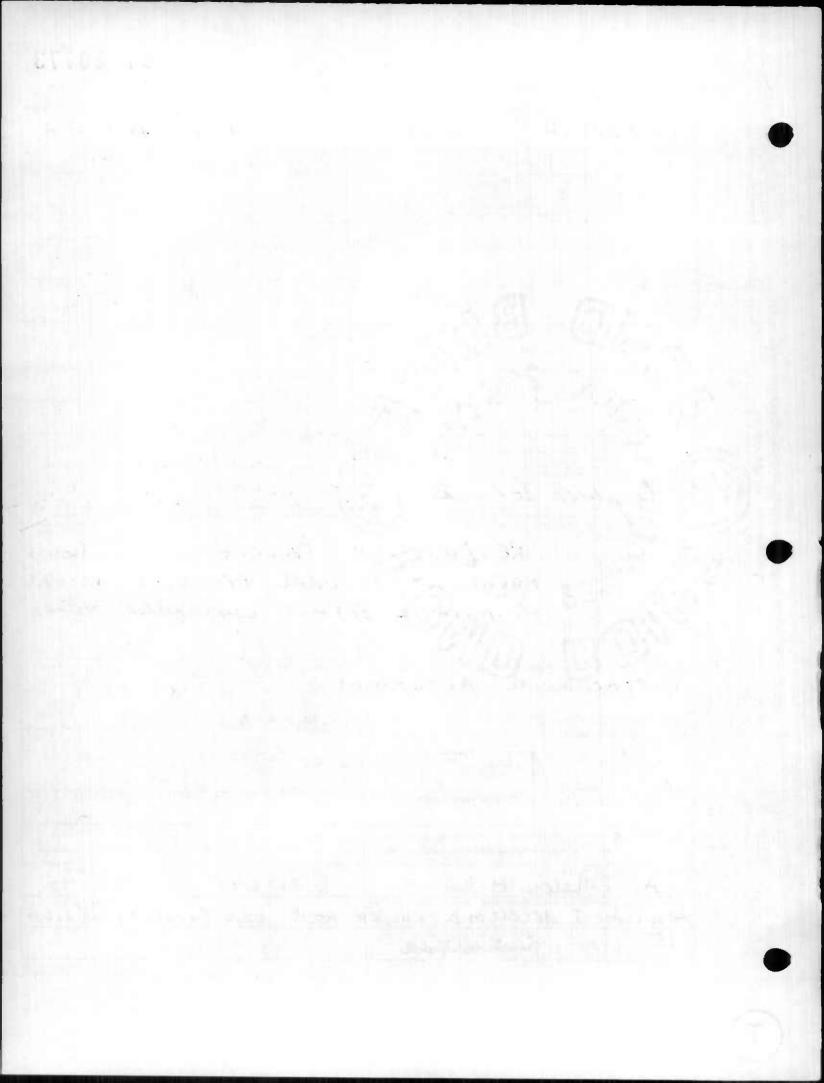
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FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	-	,	0						2. DATE OF	DEATH	NY .	/ YEAR		OF DEATH	1
	ELIZAE	BETH	ł	KI	CE					octo			77	11:	30	4 M
	4. SOCIAL SECURITY NUMB 212-30-63		5. SEX 1 M 2 X F	6. AGE (In yrs. 80		IF UNDER	1 YEAR DAYS	HOURS	24 HRS. MIN.	7. DATE OF I (Month, Da APRIL	3,19	917	Count	PLACE (S		sign
r C	9a. FACILITY NAME (If not in CHURCH HOME					9b. CITY		TIM					NTY OF C	CITY		
DIMECTOR	RESIDENCE OF DEC	10b. COUNTY	,		I too CIT	Y, TOWN C	DR LOCAT	THOM:	•					104 INS	IDE CITY	
É	MD		ITY		100.011			RE C	עחדי					LIN	ITS?	NO.
- 15	10e. STREET AND NUMBER		,111		1	רדשרו		. ZIP COD			-	10g. CITI	ZEN OF	WHAT CO		-
È	516 SOUTH	CURLEY	STREET						212	224			U.	S.A.		
BY FUNERAL	11. MARITAL STATUS  1 Never Married 2 3 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 25	ARMED	100	If yes, sp	ENDENT Cook	m, Maxica	NIC ORIGIN? (S an, Puerto Rica y:	specify Yes	or No-		E — Amerik, White,		n,
	15. DEC	EDENT'S EDUC	CATION	160	DECEDENT'S	USUAL O	CCLIPATIO	ON		16b. KII	OF BU!	SINESS/INC	DUSTRY			
COMPLETED	(Specify only Elementary/Secondary (0	highest grade	completed) College (1-4 or 5		(Give kind of the Do NOT us	work done	during mo	ast of worki	ng							
3	8	-12)	Conege (1-4 or 5			CLER	K				DRY C	LEAN	ERS			
5	17. FATHER'S NAME (First, M	iddle, Last)						18. MOT	HER'S NA	AME (First, Midd	lle, Meiden	Surname)				
	ROBERT C.	GREENS	FELDER					MAG	DALE	NA THE	ELEN					
	19a. INFORMANT'S NAME (7	ype/Print)			196. MAILING	ADDRES	S (Street a	nd Numbe	r or Rural	Route Number,	City or Tow	n, State, Zip	Code)			
2	CHARLES L.	RICE/	HUSBAND		516 S	OUTH	CUF	LEY	STRE	ET BA	LTIM	ORE,	MD	2122	4	
	20a. METHOD OF DISPOSIT	ION on 3 🗆 Rem	oval from State		E AND DATE			ame of		DATE	20c. LO	CATION —	City or To	own, State		
	Burlal 2 Cremation Donation 6 Other				LAWN	CEME	TERY			9,97	BAL	TIMO	RE.	MD		
	21. SIONATURE OF FUNERA			. ,	2 1 4			ND ADDRE								
	· Clizar	reck	seli	noke	/					EILER 8				n 14	D 21	224
CERTIFICATION	IMMEDIATE CAUSE (Findisease or condition resulting in death)  Sequentially list condit if any, leading to immediate. Enter UNDERLY CAUSE (Disease or Injuthet Initiated events resulting in death) LAS	lons, diete ling	a. RESOURTO	OF AS A CONS	ATO SECUENCE OF TIC	PL PI: B	EL	RA	L		cus	SON NON	rs MA		lear and lear	
	PART II. Other significa	nt condition	a contributing to	deeth but no	t resulting	In the u	nderiyin	g cause	given in	Part I. 24		AUTOPSY	24	b. WERE A		
MEDICAL	INTRAC	CRAA	VIAL	ANG	EUR	451	M			_   1	PERFO			OF DEA	LE PRIOR THON DE C	AUSE
- 1	DID TORACCO II	SE CONT	RIBUTE TO CA	USE OF DE	ATH Y	ES 🗆	NO [	UN	CERTAI	NA						
2	DID TOBACCO U	2E COM		28 Pt	ACE OF DEA	TH (Check	only one)									
IAN	25. WAS CASE REFERRED T		HOSBITAL	20.71		-	eth.									
SICIAN			HOSPITAL:		3 🗆 DOA	OTHE 4   Nu			lesidence	6 Other (S	pecify)					
Y PHYSICIAN:	25. WAS CASE REFERRED TEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5			☐ ER/Outpatient	26b. TIA	4 🗆 Nu	28c. IN. Wi			6 Other (S	-	INJURY OC	CURED			
P.	25. WAS CASE REFERRED TEXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5  2 Accident	O MEDICAL Pending	28a, DATE OF (Month, L	☐ ER/Outpatient	26b. TIM	4 - Nu	28c. IN. WI	DURY AT ORK?		28d, DESCR	IBE HOW	and Numbe		Route Nur	nber,	
P.	25. WAS CASE REFERRED T EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5  2 Accident  3 Suicide 8  4 Homicide  29e. CERTIFIER (Check only)  1 CERT	Pending Investigation Could not be determined	28a, DATE OF (Month, L	ER/Outpatient FINJURY Dey, Year)  OF INJURY — At , etc. (Specify)	26b. Till IN home, larm,	4 □ Nu ME OF JURY M street, fac	28c. IN. Wi 1 story, office	JURY AT ORK? YES 2	NO NO	281. LOCATI City or 1	ON (Street fown, State	and Numbe	or or Rural			ated.
COMPLETED BY	25. WAS CASE REFERRED T EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5  2 Accident  3 Suicide 8  4 Homicide  29e. CERTIFIER (Check only)  1 CERT	Pending Investigation Could not be determined	28s. DATE Of (Month, I	ER/Outpetient F INJURY Day, Year)  OF INJURY — At , etc. (Specify)  If my knowledge, examination and	home, larm, death occur	4 Num ME OF JURY M street, fac	28c, IN, William 1	JURY AT ORK? YES 2	NO NO	281. LOCATI City or 1	ON (Street fown, State	and Number	er or Rural	(a) and m	onner as s	-
BE COMPLETED BY	25. WAS CASE REFERRED T EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5  2 Accident  3 Suicide 6  4 Homicide  20e. CERTIFIER (Check only one) 2 MED	Pending Investigation Could not be determined	28s. DATE Of (Month, I	ER/Outpetient F INJURY Day, Year)  OF INJURY — At , etc. (Specify)  If my knowledge, examination and	home, larm, death occur	4 Num ME OF JURY M street, fac	28c, IN, William 1	JURY AT ORK? YES 2	NO NO	281. LOCATI City or 1	ON (Street fown, State	and Number	er or Rural	(a) and m	onner as s	-
COMPLETED BY	25. WAS CASE REFERRED T EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5  2 Accident  3 Suicide 6  4 Homicide  20e. CERTIFIER (Check only one) 2 MED	Pending Investigation Could not be determined TIFYINO PHYS RICAL EXAMINE F PERSON WITH	28e. DATE OF (Month, I. 28e. PLACE Of building) ICIAN: To the best of ER: On the best of R	ER/Outpetlent F INJURY Day, Year)  OF INJURY — At , etc. (Specify)  of my knowledge, examination and	home, larm, death occur	4 Num ME OF JURY M street, fac	28c, IN, William 1	JURY AT ORK? YES 2	NO NO	281. LOCATI City or 1	ON (Street fown, State	and Number	er or Rural	(a) and m	onner as s	-



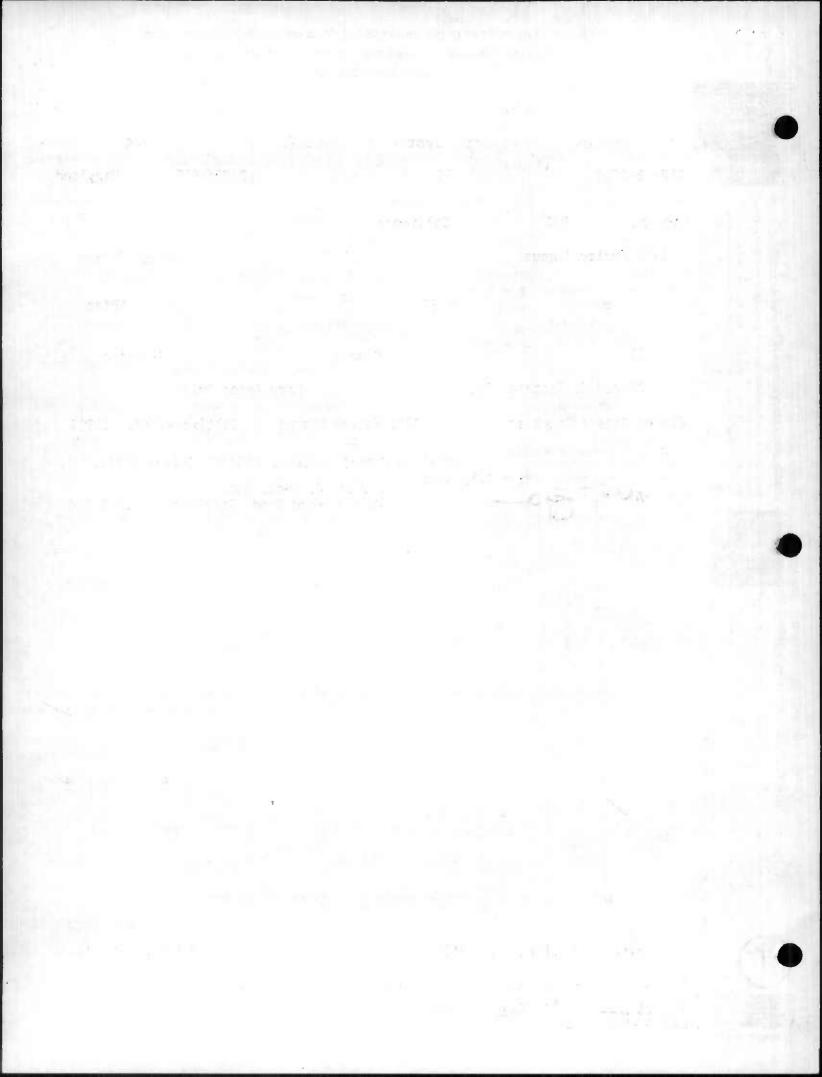


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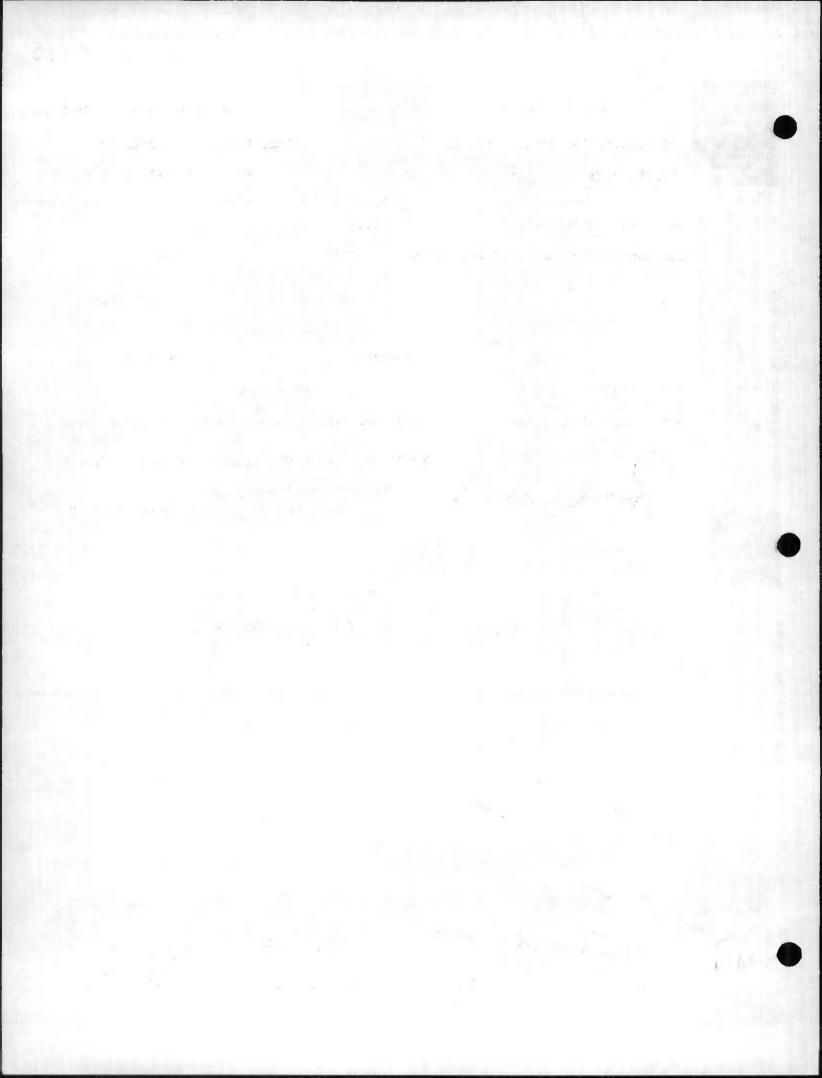
A 1 fred H. Rossman, Jr.  A Freining Physician Malfred B. Rossman, Jr.  A Freining Physician Malfred H. Rossman, J						(	Certific	cate of	Death		Reg. No.		
Alfred H. Rossman, Jr.  Function  Familiary  Alfred H. Rossman, Jr.  Function  For the posity Near (presentation, by service of number)  VA Maryland Health Care System  BallTIMORE  23-12-8614  I. My Care T. Age (in) yet accordingly it Under 1 Year (I Hubber System)  BallTIMORE  23-12-8614  I. My Care T. Age (in) yet accordingly it Under 1 Year (I Hubber System)  BallTIMORE  23-12-8614  I. My Care T. Age (in) yet accordingly it Under 1 Year (I Hubber System)  BallTIMORE  23-12-8614  I. My Care T. Age (in) yet accordingly it Under 1 Year (I Hubber System)  BallTIMORE  100c 1 Hubber System  BallTIMORE  100c 1 Hubber System  BallTIMORE  100c 1 Hubber System  BallTIMORE  100c 1 Hubber System  BallTIMORE  100c 1 Hubber System  BallTIMORE  23-12-8614  I. My Care T. Age (in) yet according to Under 1 Year (I Hubber System)  BallTIMORE  100c 1 Hubber System Sys	Physic	ian	1. Decedent's Name (First, Middle, La	est)								Year	3. Time of Death
Fundamental Director   The Control of Cont			Alfred H. Ros	ssman, Jr	•					Octo	ber 9,	1997	2:38 Al
S. Social Security Number   213-12-9614   To Sex   To S	Exami	iner	4a. Fecility Neme (If not institution, given	ve street end number)							th 4c. Cour	nty of Deeth	
213-12-8614   18/M 20 F   75 Vrs.   Months   Days   Hours   Min   3/20/1922   Marry land   Marry land   Marry land   My/A   Baltimore   10/L Copy Town or Location   10/L Inside City   10/L Copy Town or Location   10/L Inside City   10/L Copy Code   10/L Copy												T	
The part of the			213-12-8614				Mor			in. (Month, D	ey, Year)	9. Birthp Cour Ma	lace (State or Foreig stry) ryland
Janice Kane / Daughter  4409 Furley Avenue  Baltimore, Md. 21206  20b. Method of Disposition (Name of Disposition	dand dand				10c. Cit	y, Town o	r Location					1	Od. Inside City Limits
Janice Kane / Daughter  4409 Furley Avenue  Baltimore, Md. 21206  20b. Method of Disposition (Name of Disposition	the Many 28a-f sh	ector		A	В	altii		7 in Codo			10a Citizan	4 Minot Cour	1 X Yes 2 □ No
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Janice Kane / Daughter  4409 Furley Avenue  Baltimore, Md. 21206  20b. Method of Disposition (Name of Disposition	020 vurs after de al', or item	þ	1 Never Merried 2 Married	Armed Forces? 1 1 Yes 2 □ N If Yes, Give	lo		If Yes,	specify Cub	an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	В	lack, White,	etc.
Janice Kane / Daughter  4409 Furley Avenue  Baltimore, Md. 21206  20b. Method of Disposition (Name of Disposition	5-0 72 ho	ted	15. Decedent's E	ducation		16e. D	ecedent's	Usual Occup	pation	vorkina	16b. Kind of	Business/Inc	dustry
Janice Kane / Daughter  4409 Furley Avenue  Baltimore, Md. 21206  20b. Method of Disposition (Name of Disposition	2121 d within giene. r then "	omple			+)	'ii	fe. DO No	OT use retire	d)	orking	P1	umbino	
Janice Kane / Daughter  4409 Furley Avenue  Baltimore, Md. 21206  20b. Method of Disposition (Name of Disposition	off Hy		17. Fether's Name (First, Middle, Last	)						lame (First, Middle			,
Janice Kane / Daughter  4409 Furley Avenue  Baltimore, Md. 21206  20b. Method of Disposition (Name of Disposition	Aents Aents tic ex	0	Alfred H. Ro	ossman, Sr.					Mary	Agnes D	uffy		
20a. Method of Disposition   3   Removal from State   20b. Place of Disposition (Name of Contributing In the underlying cause given in Part I.  20a. Method of Disposition   3   Removal from State   20b. Place of Disposition (Name of Contributing In the underlying cause given in Part I.  20b. Place of Disposition (Name of Contributing In the underlying cause given in Part I.  20c. Method of Disposition   3   Removal from State   20b. Place of Disposition (Name of Contributing In the underlying cause given in Part I.  20c. Method of Disposition   3   Removal from State   20b. Place of Disposition (Name of Contributing In the underlying cause given in Part I.  20c. Method of Disposition   3   Removal from State   20b. Place of Disposition (Name of Contributing In the underlying cause given in Part I.  20c. Location - City of Town, State   20b. Place of Disposition (Name of Contributing In the underlying cause given in Part I.  20c. Location - City of Town, State   20b. Place of Disposition (Name of Contributing In the underlying cause given in Part I.  21. Signeture of Funeral Service Licensee Mark T. Zavoyna   22b. Place of Disposition (Name of Contributing In the underlying cause given in Part I.  20c. Location - City of Town, State   20b. Place of Disposition (Name of Contributing In the underlying cause given in Part I.  21. Signeture of Funeral Service Licensee Mark T. Zavoyna   22b. Place of Death (Check only one)   22b. Disposition (Name of Contributing In the underlying cause given in Part I.  22c. Location City of Town, State   20b. Place of Death (Check only one)   22b. Place of Death (Check only one)   22b. Place of Death (Check only one)   22b. Place of Death (Check only one)   22b. Place of Death (Check only one)   22b. Place of Death (Check only one)   22b. Place of Death (Check only one)   22b. Place of Death (Check only one)   22b. Place of Death (Check only one)   22b. Place of Death (Check only one)   22b. Place of Death (Check only one)   22b. Place of Death (Check only one)   22b. Place of Deat	and N		19a. tntormant's Name/Relationship	Type, Print)		19b. N	falling Add	iress (Street	end Number or	Rural Route Num	per, City or Tox	rn, Stete, Zip	Code)
Physician (Medical Examiner)  23e. Part I. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  23e. Part I. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part I. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part I. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part I. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part I. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part I. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part I. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part I. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part II. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part II. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part II. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part II. Enter the disease, or saw distallations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest.  25e. Part II. Enter the disease, or saw distallations that cause of the saw distallation	and 2 alth 127 le		Janice Kane / Dau	ughter		44	09 F	urley	Avenue	Balt	imore,	Md. 2	1206
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Physician    Medical Examiner	D S S S S S S S S S S S S S S S S S S S		Marke T. 7	2	.avoy	πα	Le	onard	J. Ruck		imore.	Md 2	21214
Physician (Medical Examiner)    Medical Examiner			23e. Part1. Enter the disease, of code shock, or heart tailure. List only	olications that caused	the deat	h. Do not	enter the	mode of dyle	ng, such as card	iac or respiretory	errest,	rid.	Approximate
disease or condition resulting in death)  Due to (or as a consequence ot):  Lung Cancer - Stage IV  20 Mos.  Sequentially list conditions, if any, leading to immediate the property of the pr												1	Onset end Death
Due to (or as a consequence ot):  Lung Cancer - Stage IV  20 Mos.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that inhalated events resulting in death) Last  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  Due to (or as a consequence ot):  1   Yes 2   No 3   Probably			disease or condition	Renal	Fa	ilur	е						1 Week
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death prior to completion of cause of death?  24a. Was en eutopsy performed?  24b. Were autopsy find evailable prior to completion of cause of death?  1   Yes 2   No 3   Probably 4   Death evailable prior to completion of cause of death?  1   Yes 2   No 1   Yes 2   Death evailable prior to completion of cause of death?  25c. Place of Death (Check only one)  27c. Manner of Death evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Was case referred to medical evailable prior to completion of cause of death?  27d. Place of Death (Check only one)  27d. Was case referred to medical evailable prior to completion of cause of death?  28d. Death of the cause of death of the cause of death of the cau		Je.	resulting in deality						IV			2	O Mos.
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25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)   27. Manner of Death   1	law rec	npiete								per	ormed?	co	moletion of cause
1	The The page	Con								1	Yes 20 No	10	Tyes 20 No
1	VITC clan: entific			Lie anitati				100		eath (Check only	one)		
28a. Dete of Injury (Month, Dey Year)  28b. Time of Injury at Work? 1   Yes 2   No  28c. Injury at Work? 1   Yes 2   No  28d. Describe how injury occurred	hysl this c	-		1 Le inpatiei				J DOM	4 LI Nursing	1			y)(y
3 Sulcide 4 Homicide 3 Sulcide 4 Homicide 4 Homicide 5 Specify  28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)  28e. Plece of Injury - At home, farm, street, fectory, office City or Town, Stete)  28f. Location (Street end Number or Rurel Route Nu	nding Path.	ation:	1 Natural 5 ☐ Pending		Year)		iry			28d. Describe	how Injury occ	urred	
29a. Certifier (Check only (Ch	DIVIS	Sertific	dotorminad	28e. Piece of Inju	ry - At ho . (Specif)	ome, farm	, street, fe	ctory, office				m <i>ber or Rur</i> e	I Route Number,
end manner steted.	Hospit 24 hours Funera letaly fille	edicai (	29a. Certifier 1 Certifying Pr (Check only one) 2 Medicat Exam	niner: On the basis of	examinal	wledge, d tion end/c	eath occu or Investige	rred et the tire etion, in my c	me, date end pla opinion, death oc	ce, and due to the curred at the time	ceuse(s) end , date and plac	manner as si e, and due to	lated. the cause(s)
29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)	o the	Me	29b. Signeture and title of certifier					29c. Licens	se number		29d. Date sig	ned (Month,	Dey, Year)
The M. Storplin MD P10220 October 10, 1997	T		Atte M.	Forglin	MD			P10	220		Octobe	y 10,	1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			30 Name and address of person who					C 4	not D-	1 + +	MD	2120	11
State 31 Mary Month, Day, Year) 32. Registrar's Signature	St	ate	31 Date filed (Month, Dey, Year)		-		eene	Stre	eet, Da	LILIMOT	e, MD	2120	<u>'</u>

DHMH 16 Rev 6/95



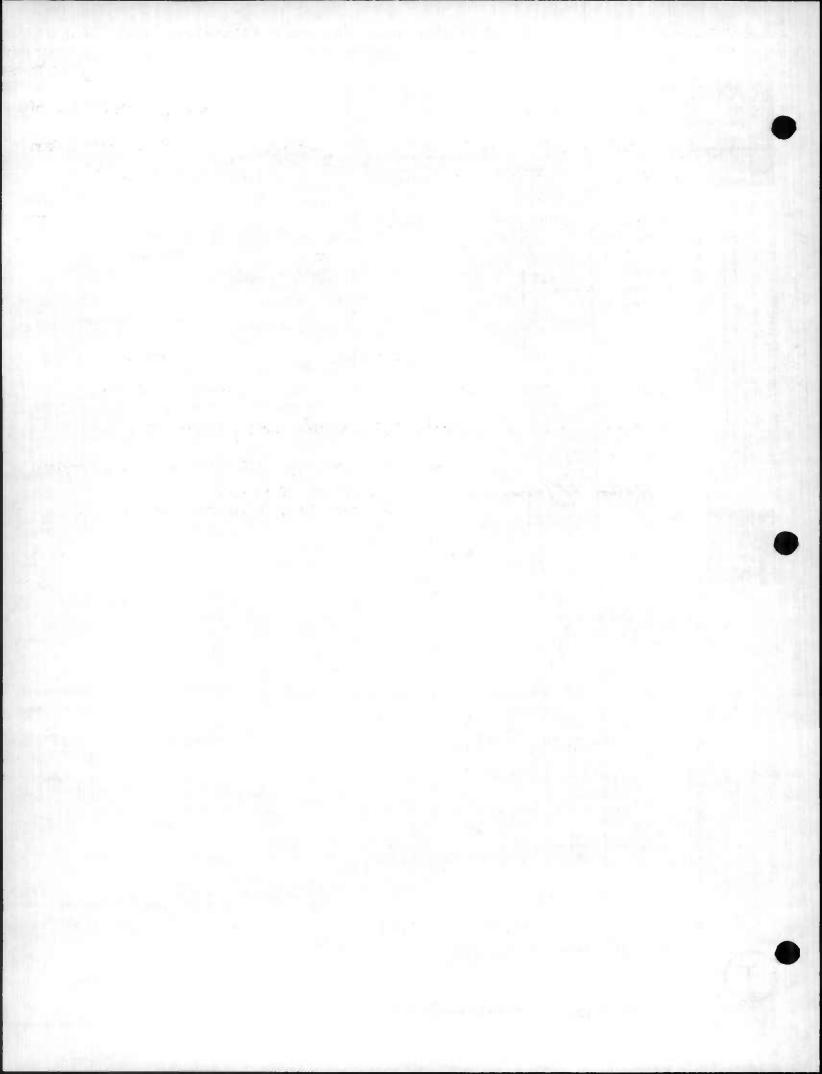
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Certifica	te of	Death		F	Reg. No.		
		1. Decedent's Name (First, Middle, L.	ast)				100		2. Dete of Dee	eth	V	3. Time of Death
Physic /Med		Nola Gertrude	Redden						Month October	6. 199	Year 7	9:10 p.m.
Exami		4e. Fecility Neme (If not institution, gi	ve street and number)				4b. City, To		ocation of Deeth		y of Deeth	Jezo pem
		Washington Adver	ntist Hospi	ital .			Tak	oma	Park	Mont	gome	rv
Funeral	Г		Sex 7. Ag	e (In yrs. last bir	Months	or 1 Yee		Min	8. Dete of Birth (Month, De)	/ Year	9. Birth	plece (Stete or Foreign
Director		578-50-9503 Usuel Residence of Decedent	ILIM ZIXIF	86	Yrs.				March 1	2,1911	West	t Virginia
and		10e. Stete 10b. County		10c. City, Tow	n or Location							10d. Insida City Limits
4 sh	0	Maryland Montgo		C+1	r Sprin	_						1 ☑ Yes 2 ☐ No
the 28	9	10e. Street end Number	omery	SIIVE	-	ip Code			Τ.	10g. Citizen of	Whet Cou	ntry?
ours efter death with the Merylan al', or items 23s or 28s-1 show Examinet must be notified at	Funeral Director	321 University Bo	oulevard We	est #205		090	1			USA		,.
death	Jera	11. Maritel Status	12. Was Decedent I					igin? (Spe	ecify Yes or No- Ricen, etc.)	14. Re		cen Indien,
ofter pr k		1 Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 N	No					Ricen, etc.)		ck, White,	
rai'.	l by	3 ₩ Widowed 4 □ Divorced	If Yes, Give Yeer or Detes:		1 ☐ Yes	2 X NO	Specify:			Speci	fy: Wh:	ite
J within 72 hours efter death with the Meryland jiene. r than "natural", or fleme 23s or 28s-f show the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16e.	Decedent's Us (Give kind of w	ork done	e durina mos	t of work	ina	16b. Kind of E	Business/In	dustry
h h h	du	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT	use retir	ed)					
The last the last		8 17. Fether's Neme (First, Middle, Las	Ø	H	lomemake	r	40.00	. 4- M	(E - ) A (: ) (		Home	
should be filed withing the Mentel Hygiene. merked other then imetic event, the M	B		0						e (First, Middle,	Meiden Sumei	me)	
should nd Men marke umatic	1º	John Gilmore	Constant	100	A4-22- A 64-	(0)		9	mmons	Ca. 0/ a/		
2 8 8 8		19e. Informent's Name/Reletionship Ruth Jessee / Dau							al Route Numbe			
permit. Peges 1 and 2 Department of Health Important: If item 27 I any Injury or other tru		20e. Method of Disposition	ignee1	20b. Plece of	Disposition (Ne	eme of		Juli	Dete	20c. Location		
Peges nent of I int: if ite		1 Burial 2 Cremetion 3 [			y, cremetory or lore Was			~	10/8	Laurel		
permit. Peges 1 ar Department of Hea Important: If Item: any Injury or othe		21 Standard of Funeral Service Lice	^	Darein			ress of Fecili		10/6	Daulei	, mai	yland
permit. Departmingorta		116 6	X	2					e, Inc.			
_		23e. Pert Enter the diseese, or com	polications that caused	the death Dor						Laurel,	Mary	land 20707
Dhualalan	18	shock, or heert feilure. List only	one cause on eech lin	ie.	iot eriter the inc	de or dy	mig, such as	Cerulec	or raspiretory en	est,	1	Intervel Between Onset and Deeth
Physician /Medical		Immediate Ceuse (Finel		~ 1 .	•						1	
Examiner	П	diseese or condition resulting in daath)	ė	de psi	ろ							2 W/4
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outed	Examiner	Sequentially list conditions	b	Due to (or as a c	consequence of	7	an	12	are			
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entificate be executed ling physician end e es the burial-transit	Medical	thet initiated events resulting in daeth) Lest	c	Due to (or es e o	onsequence of)		Yes	u-v			.	
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the a	Physician	Pert II. Other significant conditions	contributing to death bu	it not resulting in	tha underlying	ceuse g	iven in Pert I	l.	23b. Did to	obacco uee co	ontribute to	o the cause of death?
that the de led by the a detached									1 🗆 Y	es 2ENo	3 ☐ Pro	bably 4 Unknown
8 500	by									000000	T	Color all all and an area
require been si should I	etec								24a. Wes e perfor	n eutopsy med?	ev	ere eutopsy findings eilable prior to empletion of cause
ne law requires the has been signed be considered to the contractions of the contracti	Completed											daeth?
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Physician: The this certificate ral director, pag	Be	25. Wes cese referred to medical exeminer?	Hospitel:	_		-		of Deeth	n (Check only or	ne)		
this al di	To.	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 Inpatie		•	UA			me 5 Resid			(y)
ing Wite une	tion	1 ⊟Naturel 5 ☐ Panding	(Month, De)		njury M	28c. Inju	ork? ☐ Yes 2 ☐		28d. Describe h	ow injury occu	ILGO.	
a ta :: e	Certification:	3 Sulcide 6 Could not b		Inv - At home fai					28f Location (S	treet end Num	her or Run	al Route Number,
or A effer Direction	erti	4 ☐ Homicida datamined	28e. Place of Inju	(Specify)	111, 311661, 16010	iy, omoe	,		City or Tow	n, Stete)	007 07 71012	arriodic ramosi,
spital cours neral		29a. Certifier 1 Certifying Pt	nysicien: To the best o	f mv knowledge.	death occurred	at the t	ime, dete en	d piece.	end due to the c	euse(s) end m	annar as s	tated
To the Hospital or Attervilla 24 hours efter de to the Funeral Directo the property filled in by the	edical		niner: On the besis of end menner sta	exeminetion end	Vor Investigetion	n, in my	opinion, dee	th occurr	ed et the time, d	lete end plece,	end due to	o tha ceuse(s)
To the	Me	29b. Signeture end title of certifier	1 .	nn	29		nse number			29d. Dete signe		
		Molio	u			D	422	22		10/6/	97	
14/	0	30. Name end address of person who	completed cause of de	ath (Item 23a) (	Type, Print)			,	ille "	100	( )	
. /		11119 Rock	ville P	ilce		(00)	Roc	KU	ille "	2	085	) <u>_</u>
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Regist		UCI 1 0 1997	grina Daysdsor	Madaga								



State of Maryland / Department of Health and Mental Hygiene 97 30776

					Certifica	ate of	Death		Reg. I	No.	,	0011	0
I LA		1. Decedent's Neme (First, Middle, Las	st)	138				2. Dete	of Deeth		1255	3. Time of	Deeth
Physic /Medi		JAMES LORRAINE	SMALL, SR.					OCTO	BER	Ову	1997	6:45	AM
Exami		4e. Fecility Neme (If not institution, give					4b. City, Town	n, or Location of		4c. County	-		
		DOCTORS COMMUNI	ידע אטכטדעאז				Lanham	2	D	ringo	Coo	roog C	ountra
Funeral		5. Sociel Security Number 6. S	ex 7. Age (/	ı n yrs. last birt	1700)	er 1 Year	If Under 24	Hrs 9 Date	of Birth	LIRCE	9. Birthp	rges C	r Foreign
Director		218-09-3389	XM 2DF	3	Yrs. Month	s Deys	Hours	Min. (Mont	3, 1	904	Mary.	land	
70		Usuel Residence of Decedent											
how		10a. Stete 10b. County	10	c. City, Towr	n or Location						1	0d. Inside Cit	100
Me Se	cto	Maryland Prince G	eorges	Вс	owie							1 🗆 Yes	2 No
₹ 20 €	Director	10e. Street and Number			10f. Z	ip Code			10g.	Citizen of V	Whet Cour	ntry?	
th wi		15005 Health C	enter Drive			20	0716			US	SA		
ING 21213-0020 be filed within 72 hours after death with the Merylend rial Hygiene. I other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U,S.	13. Was Dec	edent of I	Hispenic Origin	n? (Specify Yes of Puerto Rican, etc	or No-		e - Americ		
o at at a		1 Never Married 2 Married	1 X Yes 2 No If Yes, Give			2[X]No		dorto Filoari, oto	,				
ours ours	d by	3 Widowed 4 Divorced	Year or Dates:		100	23,10	ороспу.			Specify	/: WI	hite	
21215-0020 d within 72 hours at jiene 7 then "natural", or then "natural", or the ways at Exam	Completed	15. Decedent's Ed (Specify only highest gre-	lucation de completed)	16e.	Decedent's Us	vork done	during most o	of working	16b.	Kind of Bu	usiness/Inc	dustry	
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filled v ther a	S		4		_Sales	man	T			Print			
be file that Hyg d othe	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's	s Name (First, M		en Sumen	10)		
Maryland d 2 should be file th end Mental Hy 7 Is marked othe traumatic event	2		uff Sma		·		Mary		erta		mith		
2 sh 2 sh 18 m		19a. Informent's Neme/Reletionship (7	Type, Print)	19b.	. Meiling Addre	ss (Stree	t and Number	or Rural Route N	lumber, Cit	y or Town,	Stete, Zip	Code)	
C-NL		Anne Marguerite F	owler (Daug	hter)	6706 L	ong I	Ridge_D	rive, L	anham	, MD	2070	5	
- u 0		20e. Method of Disposition 1 □ Bunal 2 ▼ Cremetion 3 □	Removel from State	cemeter	y, crematory or	eme of r other pla	ace)	Dete	20c.	Location -	City or To	wn, State	
Pag men ant:		4 Donetion 5 Other (Specify	A.	Green	Mount (	Crema	atory.	10/10	/97 R	altim	ore	Maryl:	and
DSAITIMORE, permit. Pages 1 er Deperment of Hea Important: If Item 2 any injury or other once.		21. Signature of Funeral Service bloom	gho	02.0011	22, Name	end Addre	ess of Facility		, , , ,	<b>G G</b>	iore,	TALLY I	arid.
_ %QE#9		Martin D. Laws	on on		Mitche	ell-V	Wiedefe	ld Home					
		Martin D. Tawa 23e. Pert1. Enter the disease, or comp shock, or heart failure. List only of	olicetions thet caused the	death. Do n	not enter the mi	YOUR ode of dy	Ing, such as ca	Baltimo	ory alrest,	aryla	ind 2	Approximate Intervel Bety	) Noon
Physician	П	over the state of	one code on court inte.								1	Onset end D	eath
/Medical		Immediate Cause (Final disease or condition	Se	2129								126	aux.
Examiner		resulting in death)	0.	1	consequence of	f):							eeks
D #	ner		. Phi	Nus	inos	a.						2 W	eeks
. BOX 08/00, death certificete be executed e ettending physician and id for use es the burlet-transit	Examine	Sequentially list conditions,	D		consequence of								
ian a		Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury									j		
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on the conde	by	Verra	ment	100	449								
necords, r		Module	ignordin	44					Wes en eu		24b. W	ere autopsy fi allable prior to	ndings
lew re les ber 3 2 sho	plet							_	periorineo		CO	mpletion of co	ause
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Phys eral d	1:0	27. Manner of Deeth	28e. Dete of Injury	28b. T	ime of	28c. inju Wo			ribe how in			//	
or Attending effector: After Director: After In by the fune	tio	1 ☑Neturel 5 ☐ Pending 2 ☐ Accident investigetion	(Month, Day Ye	ear) (r	njury M		ork? ]Yes 2∐No						
dea ctor	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Plece of Injury building, etc. (S	- At home, fer	rm, street, facto	ory, office					er or Rura	I Route Numi	ber,
P P P P P P P P P P P P P P P P P P P	Certification:	4 Homicide	building, etc. (S	Specify)				City o	r Town, St	ate)			
spita ours merai		29a. Certifier 1 Certifying Phy	vsician: To the best of m	v knowledge.	deeth occurre	d et the ti	ime, date end	place, end due to	the cause	(s) end me	enner es s	teted.	
24 Fur	edical	(Check only 2 Medical Exam	iner: On the basis of exa	aminetion end	d/or Investigation	on, in my	opinion, deeth	occurred et the t	ime, dete e	end place,	end due to	the cause(s)	1
To the Hospital or Attending Physician: Within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature end title of certifier	DR. NEELA	00 1	SI-141 2	9c. Licen:	se number		29d. I	Dete signe	d (Month,	Dey, Year)	
- 3-0		Mehai	M.D			D4	8213		i	0 - 6	5-9.	7	
-		30. Name and address of person who o	completed cause of death	(Item 22a) (	Type Print)							,	_
		Neelam Ashai			ellulle	B1	vd #	220 B	own	IM .	20	716	
Sta	ite	31. Date filed (Month, Dey, Year)	#32. Registrar's	Signature									
Registr		OCT 1 0 1997	Julia Davido	m-Aand	482								

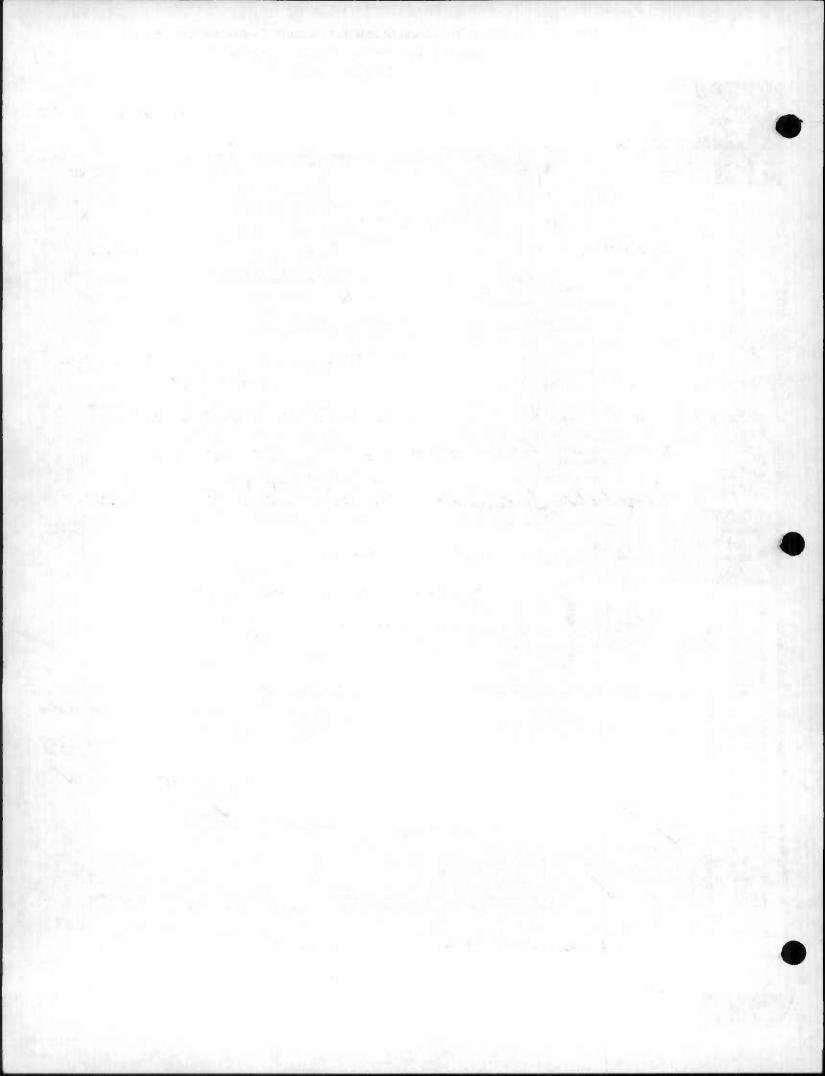


State of Maryland / Department of Health and Mental Hygiene

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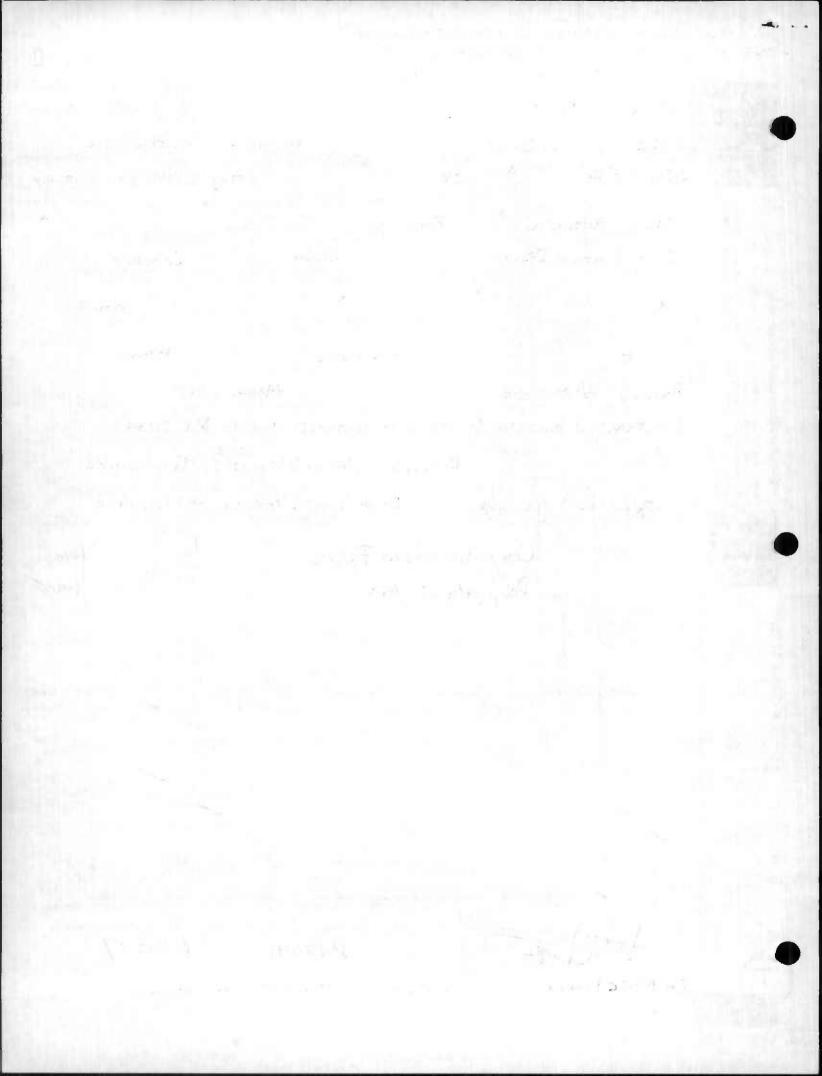
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/Medic			STUAR	r SU	LLIVAN			SEPTE	BER 20,	
xamin	er	4e. Facility Nema (If not institution, g						or Location of Deet	4c. County	/
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neral ector		220 24 5539	. Sex 7. Ag 1 X M 2 □ F	68 (In yrs. I	Yrs.	If Under 1 Months		Ain. 8. Dete of Bi	3,1929	Birthplece (Stete or Fore County)     MARYLAND
× 11		Usuel Rasidence of Decedant  10a. State 10b. County		10c. City	, Town or Loc	ation				10d. Inside City Lim
The die	tor	MD	N A		BALTIMO	RE CI	יייץ			1 Yes 2
or name 23s or 23s-1 show miner must be notified at	Director	10e. Street end Number 330 FOLCROFT S	TREET			10f. Zip C		Company of the Compan	10g. Citizen of W	/het Country? U.S.A.
r mas	Funeral	11. Maritel Stetus	12. Wes Decedent Armed Forces?	Ever in U,	S. 13. W	as Deceder	nt of Hispenic Origin? y Cuban, Mexican, Pu	(Specify Yes or No	- 14. Race	- American Indien,
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any inj		21. Signature of Funaral Service Lie	ensee	. 6	22. C	Name end	Address of Fecility S.S. ZEILI ASTERN AVI	ER & SON,	INC.	D. 21224
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he bu	Medical Examiner	Sequentially list conditions, if eny, leading to immediata cause. Entar Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Lest	bA	THEADUA to (or Hy	as a consequence of the conseque	enca of):	VASCULA	R DISE	45 &	
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detached for us	Physician/	Pert II. Other significant conditions	contributing to death bu	ut not resu	iting In the und	derlying cau	se given in Pert I.	23b. Did	tobacco use con	tribute to the cause of dea
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should be									an eutopsy prmed?	24b. Were autopsy finding eveilable prior to completion of cause
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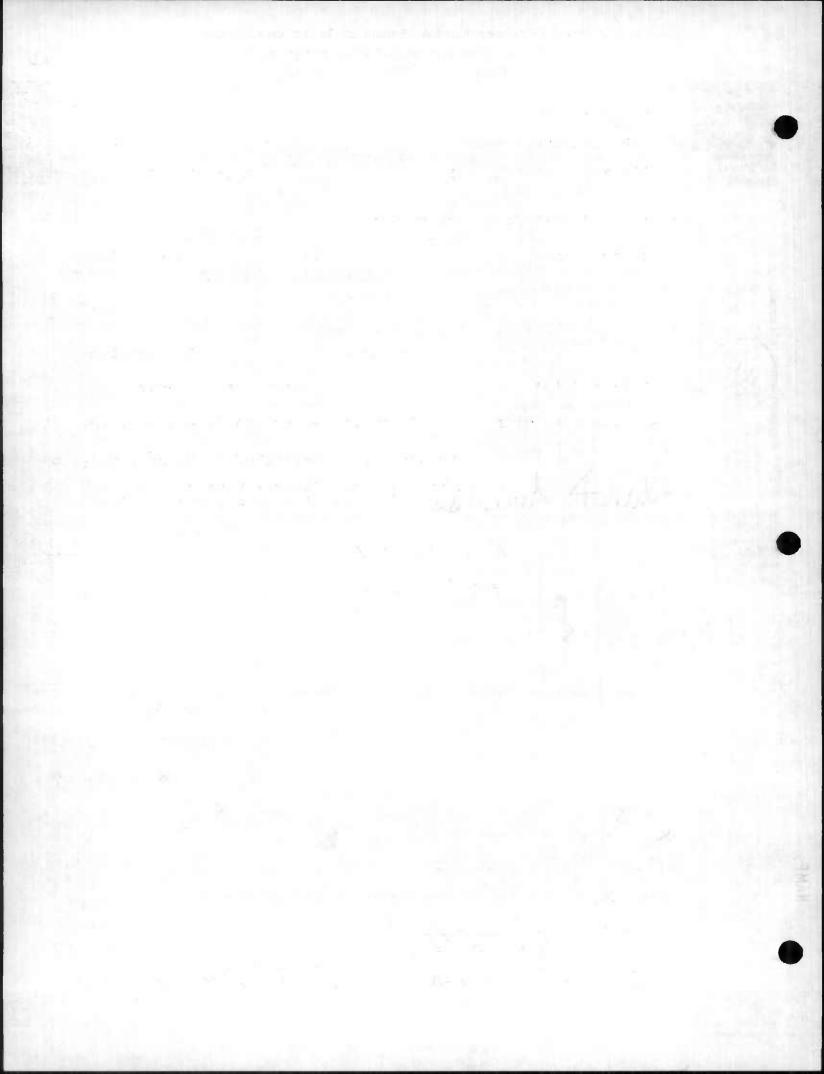
State of Maryland / Department of Health and Mental Hygiene 97 30778

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and Mantel F is marked of raumatic ever	2	RICHARD	WORA	SCHKE				M	ARIE L	OTT	_		
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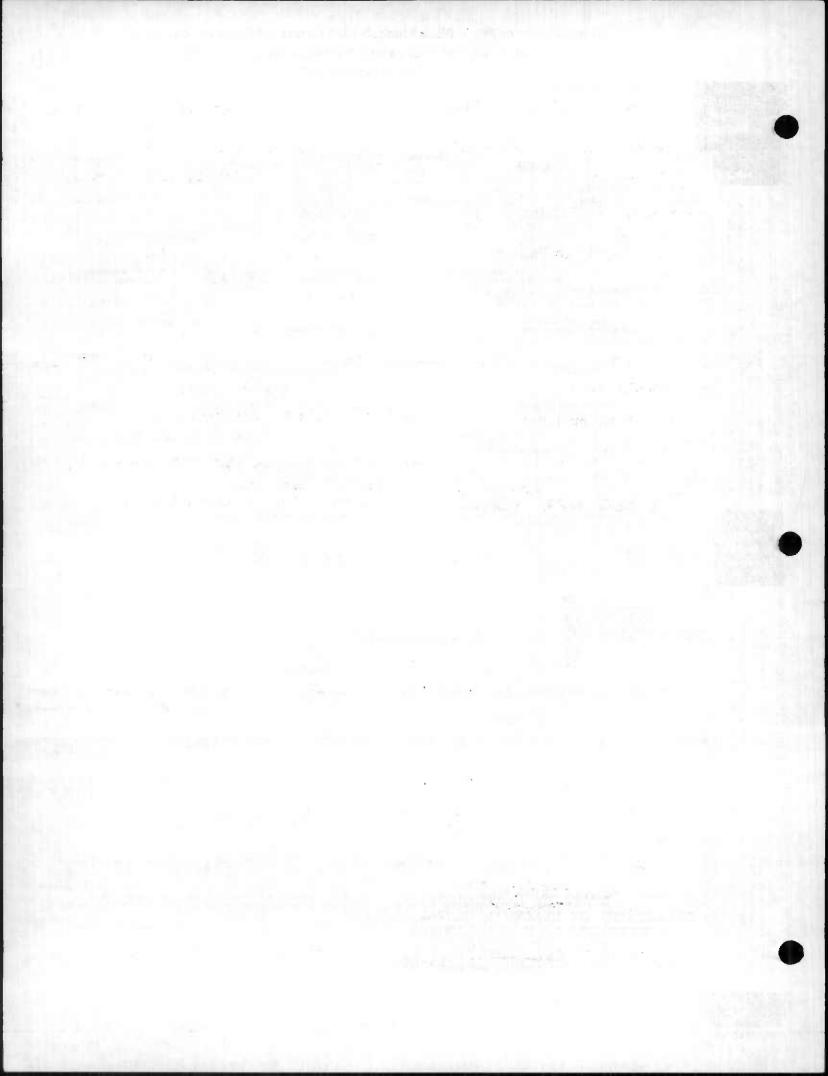
State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate o	f Death	7		Reg. No.		
Division in	12	1. Decedent's Name (First, Middle, L.	ast)		100				2. Date of D Month	eath Day	Vaar	3. Time of Leath
Physici /Medic		Michael A.	Spies						10		97	15 Now
Examir		4a. Facility Name (if not institution, gi	ve street and nun	nber)			4b. City, T	own, or Lo	ocation of Dea	th 4c. Count	y of Death	
THE R. P. LEWIS CO., LANSING		2904 Charlesto	wn Aver	nue			Lans	sdow	ne	Ba1t	imor	ce
Funeral				7. Age (In y	rs. last birthday	If Under 1 Year	er If Unde	r 24 Hrs.	8. Dete of B	irth		place (State or Foreign
Director		215-70-0863	1□M 2□F	35	Yrs.	Months Day	nours	MIII.	April	5,1962	Mai	vland
9		Usual Residence of Decedent										
anytan ahow dat		10e. State 10b. County		10c.	City, Town or L	ocation					1	Od. Inside City Limits
M - M	cto	Maryland Balt	imore		Lansdo	owne						1 ☐ Yes 23 No
vith the Marylar or 28a-f ahow be notified at	ire	10e. Street end Number				10f. Zip Code				10g. Citizen of	What Cour	ntry?
23a c	al D	301 Fifth Aven	ue			21	227			United	Sta	ates
lar deal	Funeral Directo	11. Marital Stetus	12. Wes Dece Armed For	dent Ever in	n U,S. 13.	Was Decedent o	f Hispanic O	rigin? (Sp	ecify Yes or N		ca - Americ	
		1 Never Married 2 Married	1 Yes	2 No		If Yes, specify Cu			Hican, etc.)		ck, White,	etc.
DOS DUTE	by	3 Widowed 4 Divorced	If Yes, Giv	e ates:		1 ☐ Yes 200 N	o Specify	/:		Specia	whi	ite
5-0020 72 hours at natural, or dical Exam	ompleted	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual Occ	upation	at of work	in a	16b. Kind of B	usiness/In	dustry
NATURE OF THE PARTY OF THE PART	ld.	Elementary/Secondary (0-12)	College (1	-4or 5+)	iife.	kind of work don DO NOT use reti	red)	St Of WORK	nig			
7	Son	12			Car	pender				Constr	ucti	on
E朗号	3e (	17. Fether's Neme (First, Middle, Las	•				18. Moth	ner's Name	e (First, Middle	e, Meiden Sumar	ne)	
可编码》	0	Edgar Paul Spi	es				Elai	ine	Marie	McGove	ern	
8	-	19a. Informent's Name/Relationship	(Type, Print)		19b. Mail	ing Address (Stre	et and Numi	ber or Run	al Route Numi	ber, City or Town	, State, Zip	Code)
N Spirit		Ellen G. Spies	, wife		301	Fifth	Avenu	ie L	ansdo	wne, Ma	ryla	and 21227
ore state		20e. Method of Disposition			. Place of Disp	osition (Neme of metory or other p	-		Date	20c. Location		
Page enti-		Burial 2 Cremation 3 (		State		cidge M		a11	0/11	Dorsey	. Ma	ryland
Baltimore, semit. Pages 1 a bepartment of Her moortant: If Item ny injury or othe mos.		21. Signature of Funeral Service Lice			2	2. Name end Add	ress of Faci	lity				-
B per Desp		- CHANNI	Amlo	100%	$\gamma \gamma = E$	Ambrose	Fune	eral				
		23a Part 1 Enter the disease or con		MM		2719 Ha					2122	
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on ea	ach line.	eath. Do not en	iter trie mode of d	ying, such a	s cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician / /Medical		immediate Ceuse (Final	1	)	/	1						1
Examiner		disease or condition resulting in death)	a/(	es pe	ratary	todice					i	1 wells
	7		//	Due to	(or as a conse	quence of):						
bet is	Examiner		b	Colgh	uns 0	werne						
ox 68760, certificate be asscuted ding physicien and ise es the bunal-transit	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Oue to	o (or as a conse	quence of):						
68760, ificate be axe g physicien as the bunal-	100	cause. Enter Underlying Cause (Disease or injury	c									
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Ox Ging ding se es	Me		d									
that the death or the by the ettend detached for us	lan											
O he de	Physician	Pert II. Other significant conditions	contributing to de	ath but not i	resulting in the u	inderlying cause	given in Pert	I.	23b. Did	tobacco uae co	entributa to	the cause of death?
P. d									1	Yes 2200	3 Prof	bably 4 Unknown
cords, P.O.	þ							-			_	
Records, ne law requires the law been signed to see the signed to see the law require the law requirements.	Completed								24e. Wa	s en eutopsy formed?	av	ere autopsy findings allable prior to
2 s S	be										of	mpletion of cause death?
	E O								1 🗆	Yes 2000	1 [	Yes 2 No
of Vital I	Bec	25. Was case referred to medical					26 Plac	e of Deat	h (Check only	onel		
of Vita Physician: this certific	ToB	examiner?	Hospital:	npatient 2	□ ER/Outpatie	nt 3 DOA	Mhan		10	ildence 8 🗆 Oti	ner (Snecif	ivl
Physical eral		27. Manner of Death	28a. Date o	f Injury	28b. Time o		jury at fork?			how injury occu		,
Division  or Attending after death. Director: After	ig i	1 Natural 5 ☐ Pending investigation		h, Day Year,	) Injury		/ork? □Yes 2□	] No				
/iSi	1cg	3 ☐ Suicide 6 ☐ Could not b	Zee. Placa	of Injury - A	t home, farm, st	reet, factory, offic	е		28f. Location	(Street end Num	ber or Rura	Il Route Number,
Div affe	Certification:	4 Homicide	buildin	ig, etc. (Spe	ecify)	,			City or To	iwn, State)		
Division o To the Hospital or Attending Ph Within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier Certifying Pi	ovsician: To the I	best of my k	rnowledge deat	h occurred at the	time date a	nd place	and due to the	cause(s) and m	anner ac e	teted
24 h	edicai	(Check only One) Medical Example (Check only One)	miner: On the bar and make	of exam	ination and/or in	vestigation, in my	opinion, de	ath occurr	ed at the time	, date end place,	and due to	the cause(s)
o the	₹ P	29b. Signature age little of pertillier	.//	-	11	7 29c. Lice	nse number			29d. Dete signe	d (Month.	Dev. Yeer)
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1)		- Cul	cocce	Jul	111	0	200	16	0.	UCTOL	er 7	171/
4		30. Neme and address of person who	completed cause	death (I	tem 23a) (Type,	Print) J+ 4	Lucs ,	Heret	9 Can	1.1	2	2.0
		Non CWATE	RHEU	J	70	29c. Lice  D Print) St 4  900 CA	you a	tere	Bout	· IM	0/2	-4
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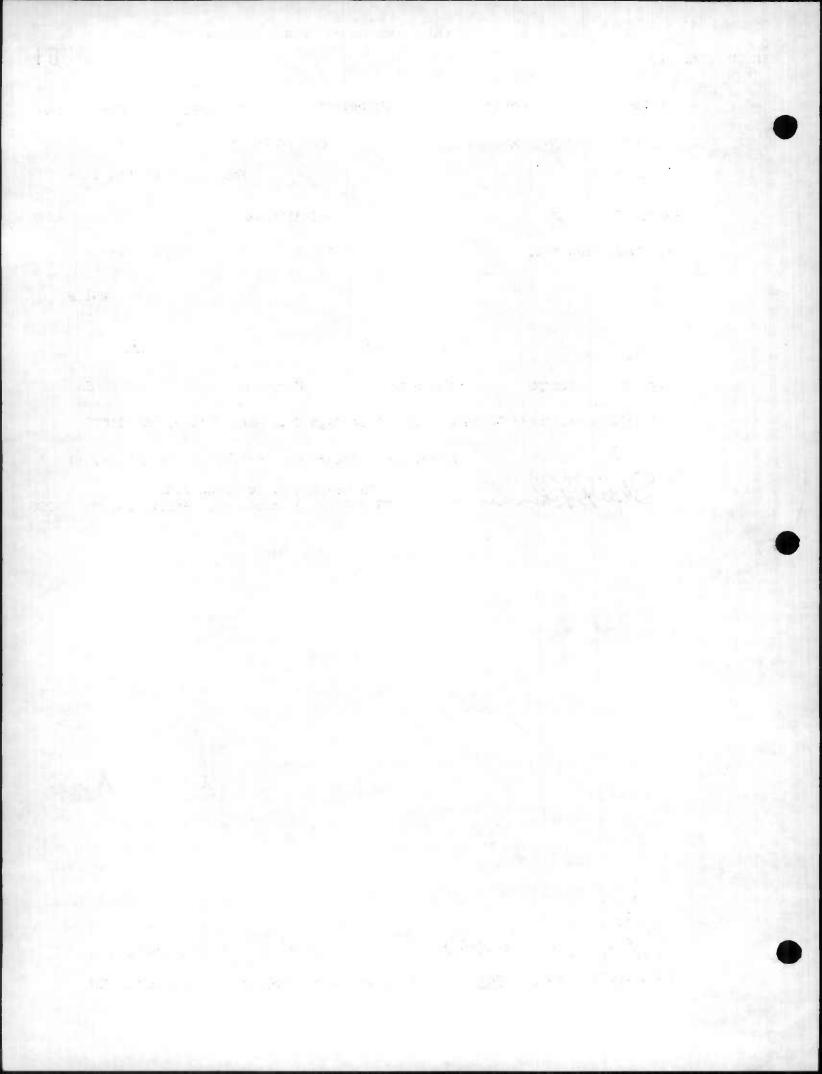
State of Maryland / Department of Health and Mental Hygiene 97

				Cei	rtificate	of Death	R	eg. No.		00100
		1. Decedant's Nama (First, Middla, La.	st)		×51= ,=		2. Date of Deat	h	West.	3. Tima of Death
Physici /Medi		MOIRA MAR	LYN SULLI	VAN			Month OCTOBE	Pay R 3, 1	Yaar 997	9:00 AM
Examir		4a. Facility Nama (If not institution, give	a street and number)			4b. City, Town, or		4c. County		0.00 /11
		Mariner Health	of Forest Hill	1		Harford	Co.	Har	ford	
Funeral		5. Social Security Number 6. S		s. last birthday)	If Undar 1 Y Months D	Harford aar Hunder 24 Hrs ays Hours Min.				aca (Stata or Foreig
Director		213-34-9800	62	Yrs.	I I I I I I I I I I I I I I I I I I I	170010		, 1935		ryland
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within 72 hours efter deeth with the Meryland ene. then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at	5		timore			re County			-   '	1 ☐ Yas 2 ☑ No
28a-	ect	10e. Street and Number			10f. Zip Co	de	4.	De Citizen of 1	Mh at Cause	
with a or	ā	4217 Mispillion	Rd		101. Zip CO	21236		og. Citizen of V USA	THAT COUNT	try r
heeth ra 23	Funeral Director	11. Marital Status	12. Was Decedant Evar in	U.S. 13.1	Was Decedant	of Hispanic Origin? (S	Specify Yes or No-		e - Amarica	an Indian
r iter	F	1 Never Married 2 Married	Armed Forcas?		If Yas, specify	Cuban, Mexican, Puer	to Rican, atc.)		ck, Whita,	
urs e	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giva Yaar or Datas:		1 □ Yas 2/O	No Specify:		Specify	Wh:	ite
2 ho	Completed	15. Decedant's Ed		16a. Daced	dant's Usuai O	ccupation		16b. Kind of B	usinass/ind	lustry
	ple	(Specify only highest gra	da complated)  College (1-4or 5+)	lifa.	kind of work d DO NOT use re	ona during most of wo atired)	rking			
T T T	NO.		*	Den	t. Mana	ner		Bankir	g Ind	dustry
of H	Be (	12th grade 17. Father's Nama (First, Middla, Last)	,	оор	o. mane	18. Mothar's Na	ma (First, Middla, A	Maiden Suman	10)	
should be filed with and Mentel Hygiene. marked other than urmatic event, the Mentel	To	Francis Lynch				Rose	e Stickli	ne		
		19a. Informant's Name/Ralationship (		19b. Mailir	ng Addrass (St	reet and Numbar or Re	ural Routa Number	City or Town,	Stata, Zip	Code)
of Health e Item 27 le other tras		R. Spencer Sull:				llion Rd.	Datcillot	e, Mu.		
of H		20a. Mathod of Disposition 1 X Buriai 2 ☐ Cramation 3 ☐		Placa of Dispo cematary, crar	osition (Nama d matory or othar	place)	Date	20c. Location -	City or To	wn, Stata
Department of I Department of I Important: If its any injury or o		4 □ Donation 5 □ Othar (Specify		Gardens	of Fai	th Cemeter	v 10-6-9	7 Balti	more.	Md.
Depent Import any inj once.		21. Signetura of Funarai Sarvice Lican		22	Nama and A	ddress of Facility  Tuneral	lome			
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		23a. Part1. Entar tha disaase, or companies shock, or heart failura. List only	olications that coused the das	th. Do not ant						Approximate
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/Medical		Immediate Causa (Final disaasa or condition	a aglun	8	,	Uple.	1 .	-		5-
xaminer		resulting in daath)		or es e consec	uence of):	worke	ruero	de s		>5 years
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0 X	Physician	Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	ndartying ceus	a given in Part I.	23b. Did to	bacco uae co	ntribute to	the causa of death
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signe d be	d by						04-199		Odb Wo	re autopsy findings
been si should	ete						24a. Was at perform		ava	ilabla prior to
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s certificate he director, page	Be	25. Was case rafarrad to medical axaminar?	Hospitai:			_	ath (Chack only on	a)		
	To	1 ☐ Yas 2 ☐ No  27. Manner of Deeth	1 □ Inpatient 2L	ER/Outpatien			loma 5 ☐ Rasida			)
After funer	ion	1 Neturel 5 ☐ Panding	28a, Deta of Injury (Month, Day Year)	28b. Tima of Injury		injury at Work?	28d. Describe ho	w injury occur	rea	
or deeth. ector: After th by the funeral	Icat	2 Accident invastigation 3 Suicida 6 Could not be				1 Yas 2 No	28f. Location (St	root and Alumb	or or Ourn	Doute Alumbar
Direction by	Certification:	4 ☐ Homicide datarmined	28a. Place of Injury - At I building, atc. (Spec	ify)	aat, ractory, on	109	City or Town	, Stata)	er or murar	Hodia Williber,
within 24 hours after deeth.  To the Funeral Director: After completely filled in by the fune		29e. Cartifiar 1 Certifying Phy	vsician: To the best of my kn	outedas death	occurred at the	se time, date and place	and due to the or	uso(s) and me	nnor 60 et	ntad
24 h Fun etely	edical	(Check only 2 Madical Exam	iner: On the best of examin and mannar stated.	etion and/or Inv	astigation, in r	ny opinion, death occu	irrad at tha tima, da	ata and place,	and due to	the ceuse(s)
o the	Me	29b. Signatura and titla of certifiar	and marries states.		29c. Lic	cansa number	25	ed. Data signe	d (Month, L	Day, Year)
s = 0		n no			7	32219				
		20 Name and address of account	ampleted cours of dear for	- 00a) (T		3-011	0	cloler	5,10	לרון
		30. Nama and addrass of person who o								
		31. Data filed (Month, Day, Year)	32. Registrar's Sign		70.					
Sta Registr	_		97 Julia Jan		-					



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.77

Division		1. Decedent's Name (First, Middle, L					2. Dete of Dea Month	th Day	Yeer	3. Time of Death
Physic /Med		Peter	Joseph		Schneide		SEPTEME	BER 27,	1997	0046AM
Exam	iner	4a. Fecility Neme (If not Institution, g	and the second second			4b. City, Town, or I		4c. County		
		"3100 LAWN VIEW A 5. Social Security Number 6.		(In yrs. last birthda		BALTIMORE  if Under 24 Hrs.			n/a	on (Ctata on Francisco
Funera Directo		129 38 4204 Usual Residence of Decedent		49 Yrs.	Months Days		8. Date of Birth (Month, Day FEB. 19	Year) 1948	New \	ice (State or Foreign y) Cork
Maryland a-1 show	tor	Maryland 10b. County		10c. City, Town or	Location	Baltimor	e		100	d. Inside City Limits 1
th with the 23e or 28	al Director	10e. Street and Number 3100 Lawn View A	ve.		10f. Zip Code	1213		Og. Citizan of V United		
13-UUZU 72 hours efter death with the Maryland 72 hours of terms 23e or 28s-4 show	by Funeral	11. Maritel Status  1 X Never Married 2  Married 3  Widowed 4  Divorced	12. Was Decadent E- Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	ver in U,S. 1	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 🏖 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		a - America ck, White, et : Wh	
within ene.	Completed	15. Decedent's I (Specify only highest g Elamantary/Secondary (0-12)	Education rade completed) Collaga (1-4or 5+	(Gi	cadent's Usuel Occu ve kind of work done n. DO NOT use retire n/a	during most of wor	king	16b. Kind of Bu		istry
	Be C	17. Father's Name (First, Middle, Las	(1)			18. Mothar's Nam	ne (First, Middle, i			
yidii buld be Mental arked o	0 8	Raymond Jos	eph	Schneide	r	Margar	et		Kun	nda
Maryland 12 should be file h end Mental Hy 7 is marked othe		19a. Informant's Name/Reletionship			eiling Address (Stree	et and Number or Ru	ral Route Number	r, City or Town,	State, Zip C	Code)
CENL		R. Ronald Schnei	der / Broth	er 26	Silver Sa	ge Ct., H	unt Vall	ey, MD	2103	30
permit. Pages 1 at peparatment of Hee tmportant: if item: any injury or other once.		20a. Method of Disposition  1 Burlal 2 X Cremetion 3  4 Donation 5 Other (Spec	☐Removel from State	cemetery, c	sposition (Name of rematory or other pla ount Crem		Data /8/97	20c. Location -	City or Tow	
Physician /Medical Examine		23e. Part1. Enter the disease, or cor shock, or haart failura. Liat onl Immediate Causa (Final disease or condition resulting in death)	MULTIF		D ALCOHOL II		es Dr., or raspiratory err	Baltimo	ore, M	D 21286 Approximate Interval Batwean Onset and Death
D #	ner			obe to (or as a cont	saquanto ony					
certificate be executed rding physician and use as the buriel-transit	Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or Injury thet initiated events resulting in death) Last	c	ue to (or as a cons						
death death death	Physician/M	Part II. Other significant conditions	contributing to death but	not rasulting in the	undarlying ceuse g	iven In Part I.	23b. Dld to	obacco uaa co	ntribute to t	the cauaa of death
thet the ed by the detache							1 🗆 Y	es 2 No	3 Proba	ably 4 Unknow
requires been sign should be	Completed by						24a. Was a perfor	in eutopsy med?	com	e autopsy findings lable prior to pletion of cause eath?
The law ate hes page 2	mo						100	as 2 No	L	Yes 2□ No
	Bec	25. Was case raferred to medical				26. Pleca of Dee	th (Check only or			
0 0	To	examiner? 1	Hospital:	t 2 ER/Outpat	ient 3 DOA	ther: 4 Dursing H	ome 5 🖾 Reside	ence 6 Oth	er (Specify)	
or Attending ther death. irector: After in by the fune	Certification:	27. Mannar of Death  1 Natural 5 Pending 2 Accident investigatic 3XX Suicida 6 Could not datarminad	100110 3/20/	Year) Injury '97 unknow	Wo	Yes 2XXX No	28d. Dascribe house in the subject i	gested dr treet and Numb n, State) 3100	ugs and	
To the Hospital or within 24 hours efti To the Funeral Dir completely filled in	edicai	29a. Certifier 1 ☐ Certifying P (Check only Medical Exa	hyalcian: To the best of minar: On the basis of e and mannar state	xamination and/or	eth occurred at the t Investigation, in my	ime, data and pleca opinion, death occur	, and due to the c rred at the time, d	ause(s) and ma late and placa,	annar as sta and due to t	ted. ha causa(s)
Vith To t	M	29b. Signature and title of cartifiar	Loleau	0		c.M.E.		9d. Data signe		
		Name and address of person who	KE, MD	111	e, Print)	eet, Balt				-
St Regist	ate	31. Data filed (Month, Day, Year) OCT 1 0 1	32. Ragistrar	Savidson-A	2. * ••					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items8,17,18 10-10-97 FilmG752 W.H.Per F/H Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Day **Physician** Dorothy Virginia October 7, 1997 Turnbaugh 7:30am /Medical 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street end number) 4c. County of Death Examiner 2330 Old Bosley Road Timonium Baltimore If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month) Year)
June 9, 19 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** Months Deys Hours 1□M 200 F 81 Yrs. **Director** 218-38-4310 1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rel', or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Timonium 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2330 Old Bosley Road 21093 USA Funeral hours efter death 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) n/a Homemaker Own Home 17. Father's Name (First, Middle, Lest) Arendale Dowling Jones 18. Mother's Neme (First, Middle, Meiden Surneme) Cecilia Be Isaac Aringdale Jones Theresa Cecelia Haulplipe 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Straet end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 iment of Health Item 27 William H. Turnbaugh, Sr./Husband 2330 Old Bosley Road, Timonium, MD 21093 Baltimore, 20b. Placa of Disposition (Neme of cametery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) Poplar Grove Cemetery 10/10/97 Phoenix, Maryland 21. Signatu of Funeral Service L 22. Name end Address of Fecllity law. Lemmon Funeral Home Clary 10 W. Padonia Road, Timonium, MD 21093 lisease, or complications that callure. List only one centre on ea Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medicai Examiner Examiner icien end burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that letters existed exists). Due to (or as e consequence of) Box 68760. physicien the buria Physician/Medical that initiated events resulting in deeth) Last Due to (or es a consequenca of): 98 use ed by the e P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown 1 Yes 2) signed t Records. by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en autopsy Completed performed' page 2 certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 📆 Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 2 ☐ ER/Outpetient 3 ☐ DOA After this funeral 27. Manner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 XNatural efter death. 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e Hospital 29a. Certifier 1 🔀 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and menner as stated. Medicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. within 2 To the 29b. Signature and 186 of 29c. License number d (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who complete

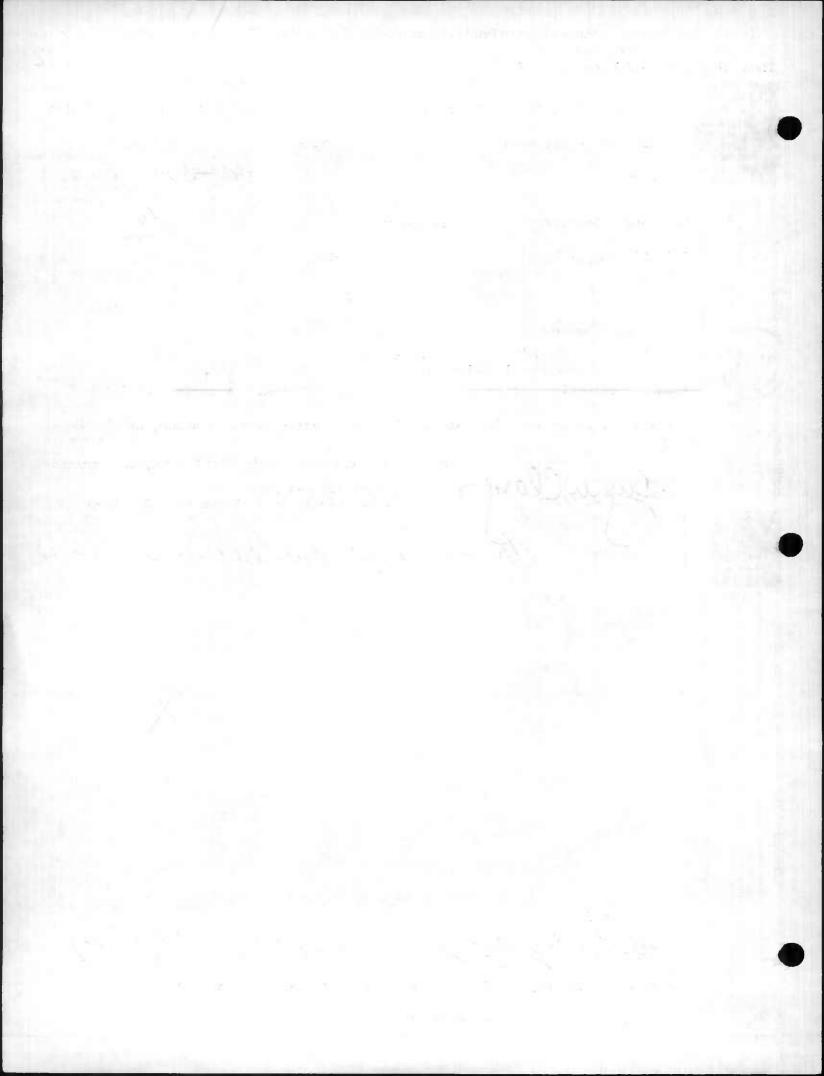
Richard L. Huslig,

32. Registrar's Signature Fichia Davidson-Randalle

MD

eted cause of deeth (Item 23a) (Type, Print)

7505 Osler Drive, suite 504, Towson, MD



State of Maryland / Department of Health and Mental Hygiene

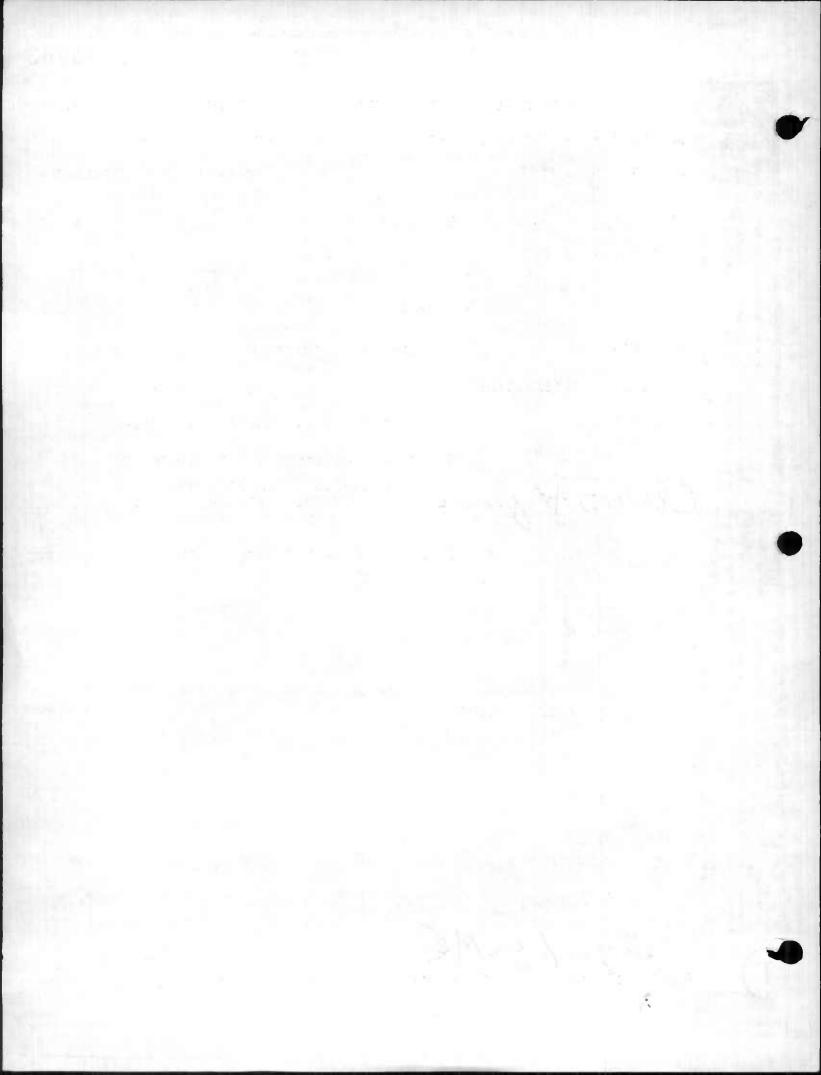
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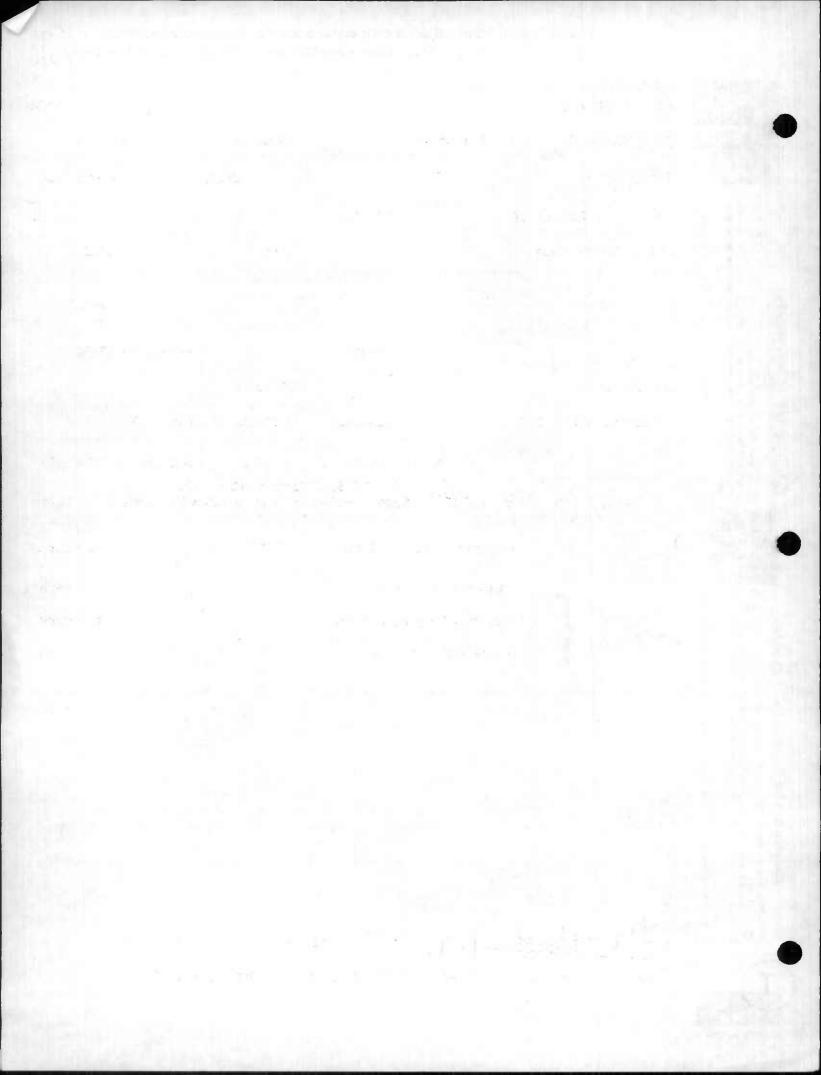
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State of Maryland / Department of Health and Mental Hygiene 97

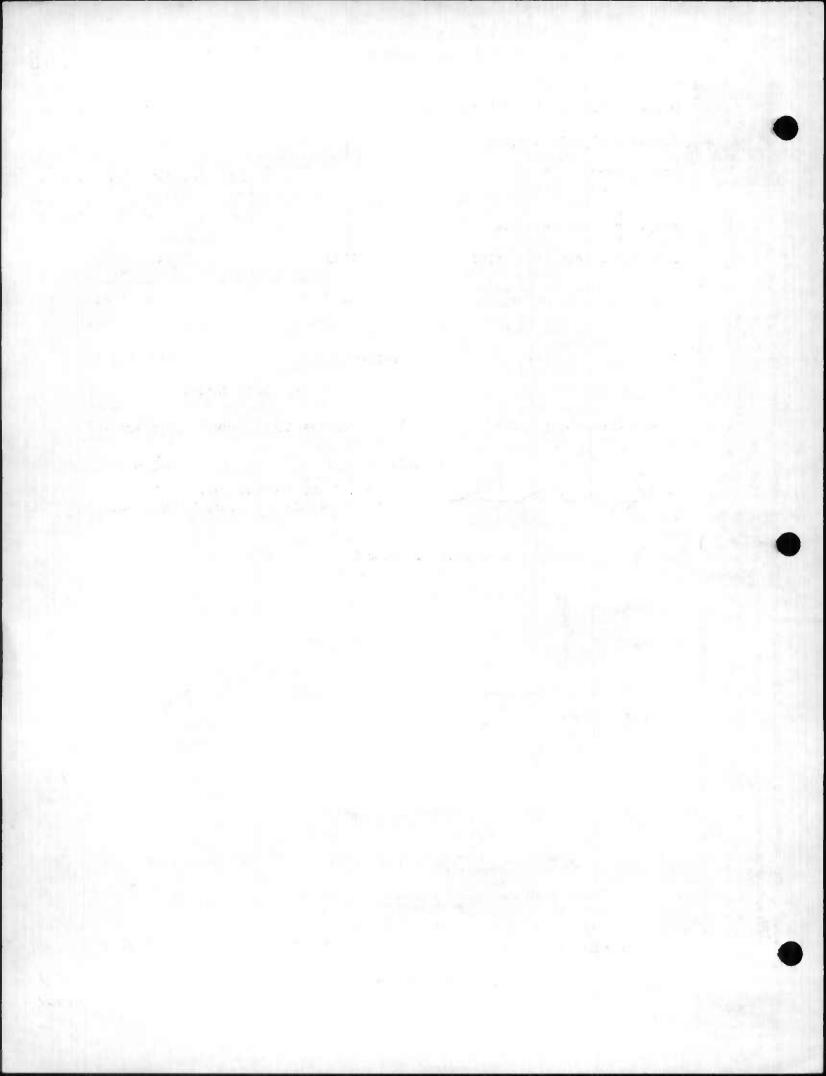
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e Marylend ta-f show ur ed at	ctor	10e. Stata 10b. County	TIMORE	10c. Cit	ty, Town or L	ocation DUNDA	LK						10d. Inside City Limits
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72 hours after death with the Manylend netural, or items 23s or 28s-f show iteal Examiner must be notified at	by Funeral	11. Merital Status  1 Never Married 2 Narried  3 Widowed 4 Divorced	Armed F	2 No		Was Deced If Yes, spec				ecify Yas or No- Rican, etc.)	14. Rai Bla Specif	ick, White,	can Indian, etc.
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ulth ar Lith ar 27 is r trau		19e. Informant's Neme/Relationship JOSEPH L. WOLA				ng Address ALDWO				i Routa Numbe K, MARY			Code)
permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other 1 once.		20a. Method of Disposition  1 Burial 2 Cremetion 3 4 Donatlon 5 Other (Spe		State	Place of Disponentery, cred	matory or o	thar pl		OCI	Dete	20c. Location		own, State  MARYLAND
death certificate be executed  Wedgical and individual and individ	ian/Medicai Examiner	23a. Part1. Enter the diseasa, or or shock, or heart fallure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Ch	Due to (o abetes i Due to (o sential	enal F or es a consec Mellit or as e consec Hyper or as a consec	ailur quence of): us quence of): tensi	e of dy					\RYLA	Approximate Interval Between Onset and Death 6 months  8 years  12 years  2 years
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To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After completely filled in by the fune	Medical	(Check only 2 Medical Expose) 29b. Signification and title of certifier	aminar: On the b	asis of examinal nar stated.	tion and/or In	vastigation, 29c Print)	In my	oplnion, dea sa number 014160	th occurr	ed et the time, o	dete and piece, 29d. Date signe 10/08,	and due to ed (Month, /97	o the cause(a)
Sta Registr	00000	30. Name and eddress of person where Harjit Singh 31. Date filed (Month, Day, Year)	, M.D.	se of deeth (Item 5410 -A	Ritc	Print) hie H	igh	way I	Balt	imore, M	/d. 212	25	

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State of Maryland / Department of Health and Mental Hygiene

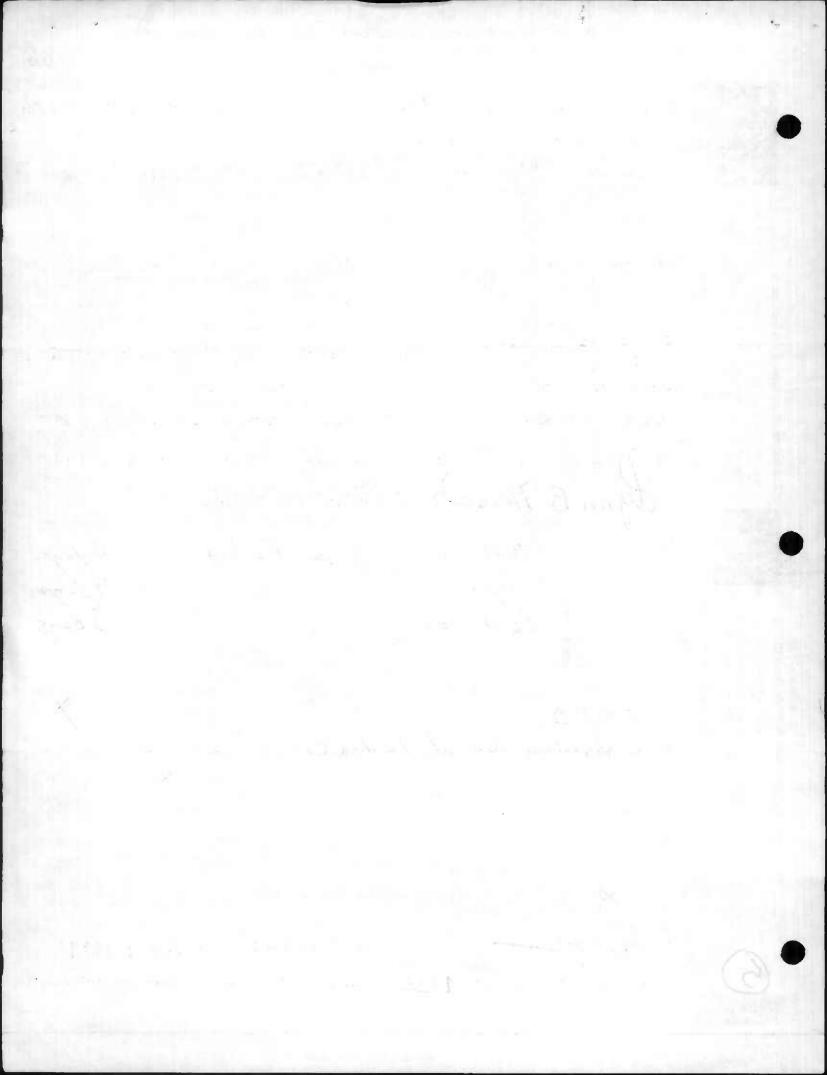
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State of Maryland / Department of Health and Mental Hygiene

30786

		Cert	ificate of De	eath	Reg. No.	00100				
	1. Decedent's Nema (First, Middle, Last)			2. Date of	Daeth	3. Time of Death				
Physician /Medical	Lawrence Will	es SR		Octo k	per 9 1	997 1:57 PM				
Examiner	4e. Facility Neme (If not institution, give street and number)		4b. (	City, Town, or Location of De	eath 4c. County					
	Union Menorial He	15 pital		Baltimore		N/A				
Funeral Director	5. Social Security Number 6. Sex 7. Age 10. M 2 □ F	Undar 24 Hrs. 8. Dete of (Month, Apri	ete of Birth Month, Dey, Year) 9. Birthpleca (State or Foreign Country) Maryland							
	Usual Residence of Decedent			1.52.2.	22/13/1	ratyrana				
al, or iteme 23a or 28a-f show Larriest must be notified at by Funeral Director	10a. Stata 10b. County	10c. City, Town or Loca				10d. fnside City Limits				
cto	Maryland N/A	Baltimor	re			Y Yas 2□ No				
ole Pre-	10e. Street end Number		10g. Citizen of Whet Country?							
a le	3322 Gilman Terrace		21211		USA					
Funeral Director	11. Meritel Stetus 12. Was Decadent E Armed Forces?	ver in U,S. 13. W		nic Origin? (Specify Yes or Maxican, Puarto Rican, etc.)	No- 14. Reci	e - Americen Indian, k, White, etc.				
by	1 Never Married 2 Married 1 Yes 2 N If Yes, Give Year or Dates:	0		pecify:	Specify					
Completed	15. Decedent's Education (Specify only highest grade completed)	(Give ki	ent's Usuel Occupetion ind of work done during O NOT use retired)	n ng most of working	16b. Kind of Business/Industry					
JE C	Elementary/Secondary (0-12) College (1-4or 5-	Shippi			Cocme	etic Manufactur				
Ü	17. Fether's Name (First, Middle, Last)	5.1255		. Mother's Name (First, Mid	THE RESERVE TO SERVE THE PARTY OF THE PARTY					
To Be	William B. Wiles			Delcie K	ing					
-	19a. fnforment's Neme/Relationship (Type, Print)	19b. Meiting	Address (Street end	Number or Rural Route Nu		Stete, Zip Code)				
í	Virginia Wiles Wife	-				Maryland 21211				
1	20a. Method of Disposition	20b. Plece of Disposi	ition (Name of	Dete	20c. Location -	City or Town, State				
	1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State		Park Ceme	tery 10/11	Woodlas.	n, Maryland				
	21. Signature of Fanarel Service Licensee	1	Name end Address o		WOOdlawi	i, Maryland				
eny injury or other traumatic event, the Medical once.  To Be Completed	A Wa	) Bu	rgee-Hens	s Funeral Hor	ne 212	11				
	23a Part Fried to disease or complications that caused			Road, Baltimo		Approximete				
	23a. Pert Entry le disaesa, or complications that caused shock, or the in failure. List only one cause on each line	e.	the mode of dying, o	don do donado on respirator	y 01100t,	Intervel Between Onset end Deeth				
an cal	fmmediate Cause (Finel	0 10	0	I 1		1/ 1				
er	disease or condition resulting in death)	Syrten	Organ	- Failm		Tday				
e la	C.	Due to (or as a consequ	ence of):			41				
E	b. ages	Due to (or as a consequ				days				
Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	Jue to (or as a consequ	ence or):			21 -				
	Cause (Disease or Injury that initiated events	Due to (or as e conseque				JUAYS				
Medical	resulting in death) Last	oue to (or as e consequi	ence or):			V				
Physician	d									
ysic	Pert ff. Other significant conditions contributing to death bu	n Pert I. 23b. D	23b. Did tobacco use contributs to the cause of death							
	COPD	1	1 Yss 2 No 3 Probably 4							
d by Physician/Me		1	/ \ /	040.14	es an eutopsy	24b. Were autopsy findings				
Completed	Chronic RE	NA/ PA	11/URE	248. Vi	erformed?	evaileble prior to completion of ceuse of deeth?				
E				1	Yes 2 No	1 ☐ Yes 2 ☐ No				
Be	25. Was case referred to medical		26	6. Place of Death (Check or	ly one)					
ToB	examiner?  1 Ves 2 No Hospitel: 1 Inpatier	Monitol:								
in: To Be Com	27. Manner of Death 28e. Dete of Injun		be how Injury occur							
atlo	2 Accident investigation	2 🗆 No								
Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of fnju building, efc.									
O										
edical	29a. Certifier  (Check only one)  Certifying Phyatcian: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) end manner as stated.  Check only one)  Certifying Phyatcian: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) end manner as stated.  Check only one)									
completely filled in by the funeral Medical Certification: 1	29b. Signeture end title of certifier	29c. License nu			d (Month, Dey, Year)					
	- m		AT2 43	8946	October	9 1997				
\	30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)  Warren R. Dunn MD 1910 Sulgrave Ave #ZE Bultimore Mo									
1	Warren R. Dunn MD	1910	Sularave	Ave #Z	E Bultin	noic MD 21209				
State	31. Date fited (Month, Dey, Yaer) / 32. Registra	r's Signature	7	117						
egistrar	OCI 10 1997 Suna Para	son-Manage								



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** MORRIS Month -34 OCTOBIN /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of De Examiner HOSATAL 2-ANDALIS ZOWN MONTHWEST 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth Months | Days | Hours | Min. (Month, Day, Year) 5. Sociel Security Number Birthplece (Stete or Foreign Country) **Funeral** 1₽M 2□F 215-40-9567 Director MARYLAND Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at RANdAIISTOUN 1 Pres 2 □ No Director HOWARD 10e. Street end Number 10g. Citizen of Whet Country? ö permit. Pages 1 and 2 should be filed within 72 hours effer death w Depertment of Health and Mental Hygiens I important: if item 27 is merked other than "natural", or items 23s eny injury or other treumatic avant 4.5.7 5509 NORTHGREEN Rd Funerai 12. Wes Decedent Ever In U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Yes 2 100 If Yes, Give Yeer or Detes: 1 Never Merried 2/12 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No by Specify: BUACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) LADOR Beth Steel Corp 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) William A. West Ruby TAYLOR 19e. Informent's Name/Reletionship (Type, Print) PeggyWEST-20e. Method of Disposition 5509 North green Rd. BALto. Md. 21244 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from Stete 4 Donetion 5 Other (Specify) 16/9/97 BAUS- Ind. OSCHELL COMETERY 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility/ 1639 N. BREADWAY Buto. Md. 21213 23a. Perti. Ehter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Approximate Interval Between Onset and Deeth Physician /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner pue Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Box 68760. physician Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Disendon Records, þ should be 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Be Completed 24e. Wes en eutopsy performed? page 2 1 ☐ Yes 2 ☑ No Division of Vital or Attending Physician: ofter death. director, 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 2 No Certification: To 1 Yes funeral 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide Hospital on 24 hours of Funeral Distriction 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

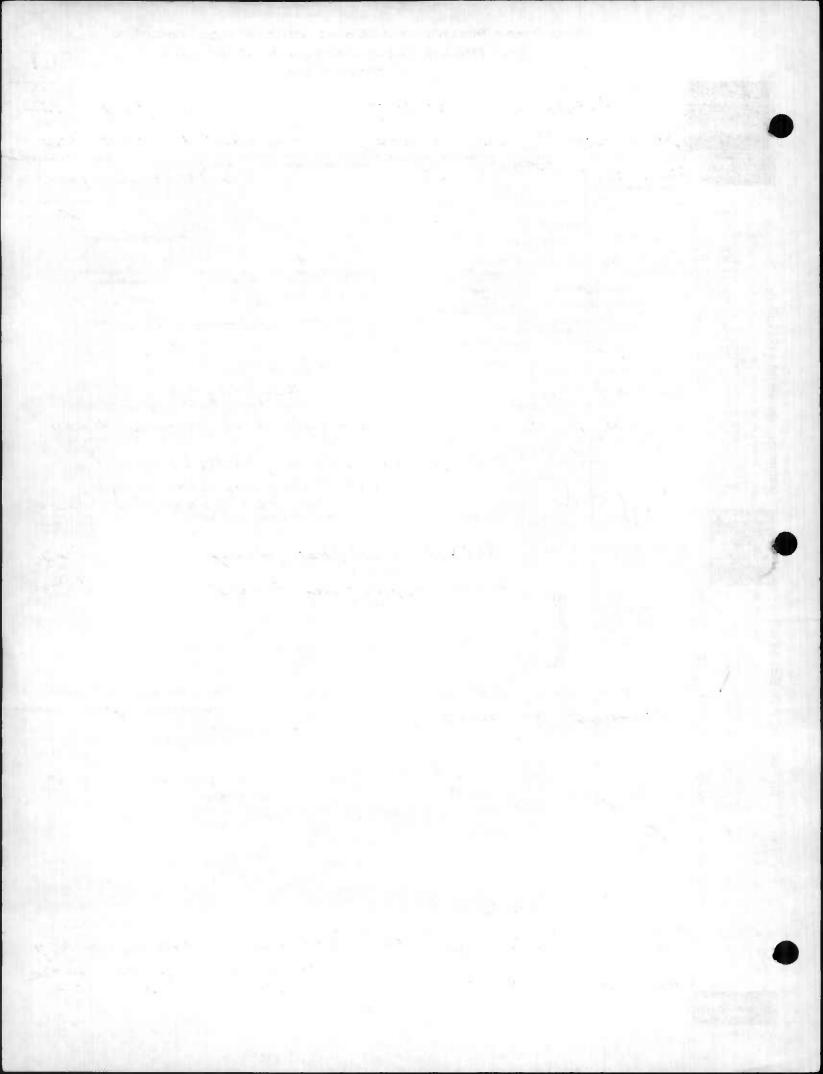
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, dete end pleca, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 219502 DETOREN NOTTHING HOSPITAL CENTER 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) CONTAUTU ORLANDO 31. Dete filed (Month, Day, Year) 32. Register's Signature

Suna Davidson-Randette

State

Registrar

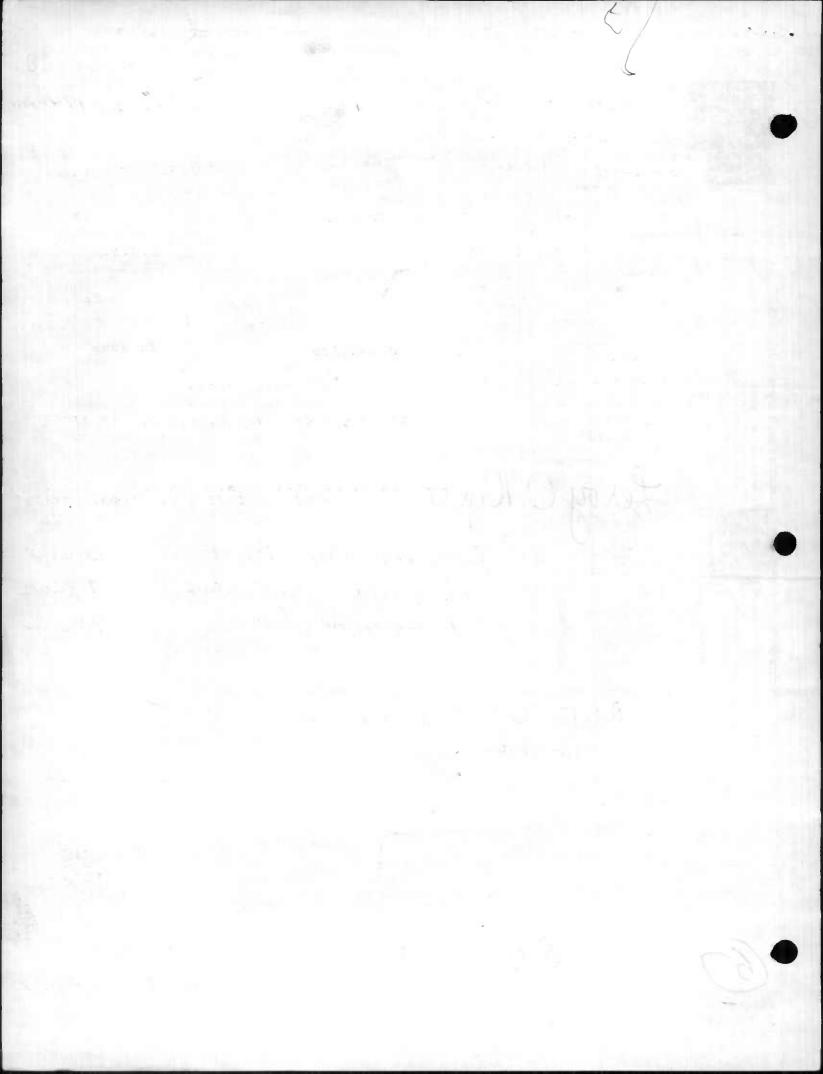
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State of Maryland / Department of Health and Mental Hygiene 30788 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey 5, **Physician** Month 1748PM NERTHA BELLEYOUNG OCTOBER 1997 /Medical 4b. City. Town, or Location of Deeth 4a. Facility Nama (If not institution, giva street end number) 4c. County of Deeth **Examiner** SINAI HOSPITAL OF BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 8. Dete of Birth (Mooth, Dey, Year) 01/10/1927 9. Birthpiece (Stete or Foreign Country) Virginia 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 T F 228-22-8834 70 Yrs Director Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner mast to notified at 1 ☑ Yes 2 ☐ No Director MD N/A BALTIMORE 10f. Zip Code 10e. Street end Number 10g, Citizan of Whet Country? 3815 GWYNN OAK AVENUE 21207 U.S.A. death Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bieck, White, etc. 72 hours efter 1 ☐ Yes 27 No If Yes, Giva Yaer or Detes: 1 ☐ Never Married 2 ☐ Marriad Maryland 21215-0020 1 Tes 2 No Specify: by Specify: B lack 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mentel Hygiene. Important: if them 27 is marked other than "important: if them 27 is marked other than" any injury or other traument. Elementery/Secondery (0-12) College (1-4or 5+) In Home Domestic 12th 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumama) Be George Jones Beulah Jones 19e. Informant's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amelia Rutledge 3815 Gwynn Oak Avenue, Balto., MD 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Burlal 2 Cramation 3 Removal from State King Memorial Park 10/11 Randallstown, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licepassi 22. Neme and Addrass of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 complications that cause the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, only one ceuse on each ha. Approximete Interval Between Onset and Deeth Physician /Medica! Immediate Ceuse (Finel audionspir atory disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Due to (or es a consequence of): sician and buriel-transit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events rasulting in deeth) Lest Coronay AWE
Due to (or es e consequence of): physician s the burie Records, P.O. Box 68760 8 Physician/Medical 80 ettending ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Dfd tobacco use contribute to the cause of death? been signed by should be detec 1 Yes 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings eveileble prior to complation of cause of deeth? Hyrelijo damia 24e. Wes en autopsy performed? Completed hes 2 No 1 ☐ Yes 1 Yes 2 No Division of Vital 25. Wes cese referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2₽No this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 \( \text{Homicide} \) 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the basis of exemination and/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier Medicai 29b. Signeture and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Yaar) 3, 3449 Wiltens Avenue Butt, Md. 212,29 30. Neme end eddress of pe 60 31. Dete filed (Month, Day, Year, State 1 0 1997

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM#16a&b PER NF.H. FLM#G752 10.14/97 J.A. Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Yaar DORIS ANDERSON October 97 0655 /Medical 4e. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat, **Examiner** THE JOHNS HOPKINS HOSPTIAL BALTIMORE CITY
If Under 24 Hrs.
Hours Min.

8. Data of (Mopth, If Undar 1 Year 5. Sociei Sacurity Numbar 7. Aga (In yrs. last birthday) 8. Data of Birth (Mopth, Day, 9. Birthplece (Stata or Foreign Country) **Funeral** 1□M 20XF Months Days 212-42-156 Usual Residence of Dacedant 55 Yrs. Director with the Maryland 10a. State 10b. County show 10c. City, Town 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Immortant: if frem 27 is merked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, it is refused from that be notified as any injury or other traumatic event, it is refused from the permitties. 1 Yas 2 No Director 10e. Street and Numbar 10g. Citizan of What Country? Funeral Was Decedant Ever in U,S Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuban, Maxican, Puerto Rican, atc.) Rece - American Indien, Biack, Whita, atc. 1 Yes 2 No If Yas, Giva Yaar or Detas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1□Yes 2□No by 3 Widowed 4 □ Divorced Specify. Completed 16a. Decedant's Usual Occupation
(Giva kind of work dona during most of working life. DO NOT usa retired) HUUSEKEEPER 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry HOSPITAL Coilega (1-4or 5+) Elementery/Secondary (0-12) 17. Fathar's Na me (First, Middla, Last) 18. Mother's Name (First, Middla, Meidan Sumama) Be To 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number of Rurel Routa Number, City or Town, Stata, Zip Coda) 2611 20b. Piace of Disposition (Noma of cematary, cremetory or other place) onument 20a. Method of Disposition Data 1 Buriai 2 □ Cremation 3 □ Removei from Stata 4 Donation 5 Othar (Spacify) Menional Park 21. Signatura of Funarel Service Licensa 22. Nama and Address of Fecility Enter tha disaase, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrast shock, or heart tailure. List only one cause on each line. Approximata Interval Batween Onset and Death Physician /Medical Immedieta Ceusa (Final disaasa or condition rasulting in death) aspiration 20 minutes **Examiner** Dua to (or as a consequence of) Physician/Medical Examiner multiple cercbrovescular accidents The law requires that the death cartificate be axecuted the burial-transi Sequantielly list conditions, if any, laeding to immadiate causa. Enter Undarlying Ceusa (Diseesa or injury that initiated avants resulting in daath) Last Dua to (or as a consequance ot): P.O. Box 68760, hypertension 20 years Due to (or as e consequenca of): signed by the at Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown polymicrobich Supsis Division of Vital Records, Completed by 24b. Wera autopsy findings availabla prior to complation of cause of deeth? 24a. Was en eutopsy performed? ganguene right heel page 2 2 No 1 Yas 20 No 1 🗆 Yas dichetes mellitos Attending Physicien: 25. Was casa refarred to madical axaminer? Be 26. Placa of Daath (Chack only ona) Hospital: 1 Inpatient 1 ☐ Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Mannar of Death funeral 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Yas 2 No death 2 Accident after death Director: Could not be datarmined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, tactory, office building, atc. (Spacify) ed in by 4 Homicide ò 29e. Cartifier 🗹 Certifying Phyatolan: To the bast of my knowledge, death occurred et tha tima, data and place, and dua to the cause(s) and menner es stated. Medicai 2 Medical Examiner: On the basis of exeminetion end/or invastigetion, in my opinion, death occurred at the time, date end place, end due to the causa(s) and manner stated.

To the

State Registrar

31. Data tiled (Month, Dey, Year)

HD

30. Nama and address of person who completed causa of daath (Itam 23a) (Type, Print)

29b. Signeture end titla ot certifiar

Brian

32. Registrer's Signatura gula Davidson

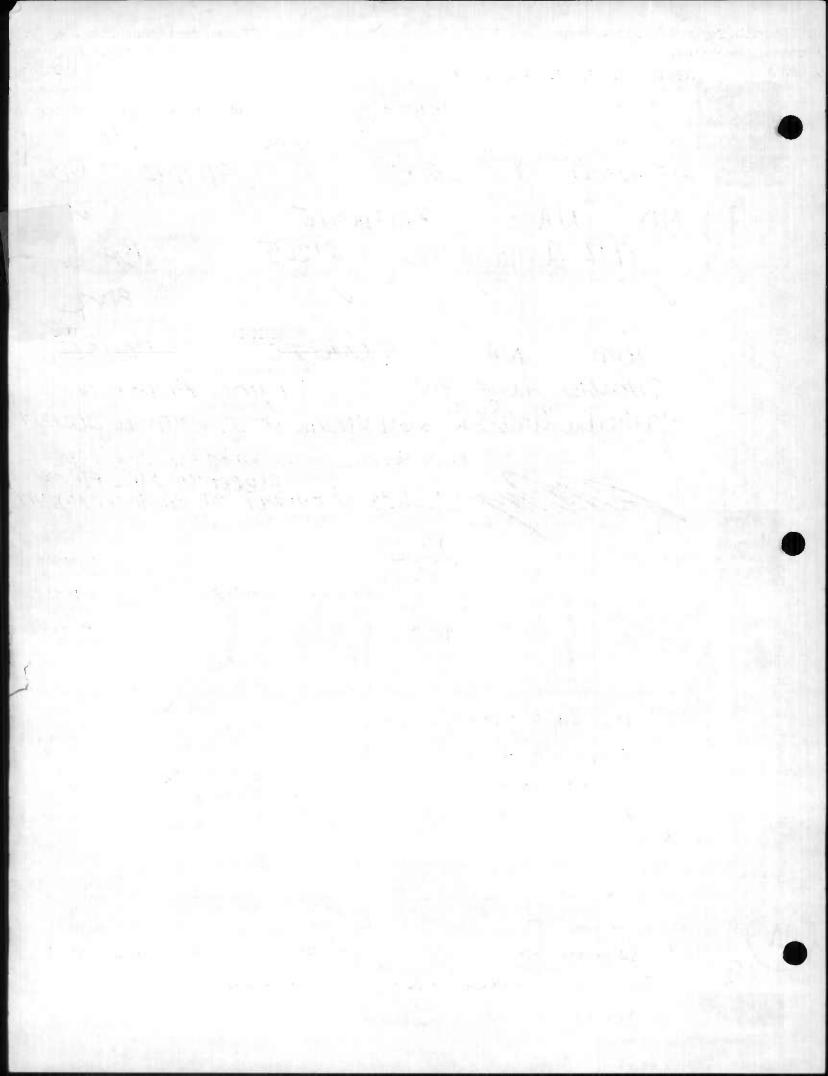
29c. Licansa number

600 NORTH WOLFE ST BALTIMORE MD 21205

RES 000

29d. Data signad (Month, Day, Year)

OCTOBER 11, 1997



State of Maryland / Department of Health and Mental Hygiene

					,,,,,,,	Certif	icate o	f Death		Reg. No.	/ 30	190	
Physician /Medical	MOKKIS MORFIS ANDREWS								OCTOBER 11 1997 1			Tima of Death Q: 20 pm	
Examiner			SKINS	HOSPIT			lui e	4b. City, Town, or BALTIM			ty of Death	RE .M	
Funeral Director		Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24					r If Under 24 Hrs	8. Data of Bi	irth ay, Year)		(State or Foraign		
Pu .	-	Usual Residence of Dacad			40 00	-							
death with the Maryland ms 23a or 28a-f show r must be notified at neral Director			County	RE		. Town or Location	on			Inside City Limits  May 2 No			
vith the Mar or 28s-f st be notified	3	10e. Street and Number			Dul		10f. Zip Coda 10g. Citizan of W						
Mily Sa or		2312 Aike	n St	reet			2121			USA	virial Country?		
r items 23anner must	2	11. Marital Status		12. Was Dacedani					Specify Yas or N	o- 14. Re	ace - Amarican f	ndian,	
ors arrest	3	Naver Married 2		Armed Forces?  ★☆Yas 2☐No If Yes, Giva Yaar or Dates: Army		1 Ves 2 No Specific					Black, Whita, atc.  Specify Black		
"natural"		15. Do	ecedant's Ed	ucation da complatad)		16a. Decedent's Usual Occupation			16b. Kind of Businass/Industry			ry	
E CE	The state of the s	Elementary/Secondary	(0-12)	Collega (1-4or 5+) NA		(Give kind of work done during most of work life. DO NOT use ratired)  Laborer					rious trades		
ital Hyg d other event,	3	17. Fathar's Nama (First, I Morris And				18. Mothar's Nan Edith		me (First, Middle, Malden Surname					
nd Mental Hygie marked other turnatic event, in	-								h Planter  Aural Routa Number, City or Town, Stata, Zip Coda)				
th and the und traum		19a. Informant's Name/Re Earl Plant		ypa, Print)						-			
ont of Hea vir. If Rem 2 v or other		20a. Mathod of Disposition			20b Pl			e Road I	Data		a - ZIZ.		
		1 ☑ Burlai 2 ☐ Cran	nation 3 🗆			aca of Dispositio matary, cramato							
	-	4 ☐ Donation 5 ☐ O  21. Signatura of Funaral S			VO			Gardens ress of Facility					
Departm Importar any inju		b 4	tion .	41								d 21202	
	+	Race M. Ross WM.C.March FH 1101 E. North Avenue  23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between											
hysician /Medicai Examiner	я.	Immediate Causa (Final diseasa or condition rasulting In death)			ASTI		LUN	UG CAN				arval Between set and Deeth	
physicien and the burlat-transit dical Examiner		Sequentially list conditions if any, leading to immedia causa. Entar Undarlying Causa (Disaase or Injury	s. f	Due to (or as a consaquence of):									
as the		that initiated evants resulting in death) Last		Due to (or as a consaquance of):									
stending for use	-												
igned by the attendit be detached for use by Physician/R		None	onations co	ntributing to death t	ributing to death but not rasulting in tha underlying causa givan in Part I.					23b. Did tobacco use contribute to the cause of death  Yes 2 No 3 Probably 4 Unknown			
should should									24a. Was perf	s an autopsy ormed?	availab	autopsy findings ble prior to ation of cause h?	
The law arts has page 2									10	Yas 2 No	1 □ Ya	s 200No	
partificate rector, pa		25. Was casa referred to r	nedical	26. Place of Death (Check only one)									
this ca		examinar?		Hospital:	ant 2DE	R/Outpatient 3	DOA C	ther	loma 5□Ras		ther (Specify)		
		2 Accidant	Panding invastigation	(Month, Da	28a. Data of Injury (Month, Day Year) NO INJURY  M  28b. Tima of Injury Work? 1 Yes 2 No				28d. Describe	how Injury occu	urred		
The other death.  The after death.  The Director: After the farmer of the farmer.  Certification:		4 Homicida	Could not be datarmined			na, farm, straet,	-		City or To	wn, Stata)	ber or Rural Ro		
Policy Inch		29a. Cartifiar (Check only one)	ertifying Phy adical Exam	alcfan: To tha best Iner: On tha besis o and manner si	of examination	ledge, death occ on and/or invasti	curred at tha gation, In my	tima, data and place opinion, daath occu	e, and due to the irred at tha time,	ceusa(s) end n , date and place	nannar as stated , and dua to tha	l. causa(s)	
S S S S	1	Signature and title of	oertifier	200			1 1 1 1 1 1 1 1 1	nse number		-	ed (Month, Day,		
		M.D. RES-OOD OCTOBER 11,									, 1997		

30. Nama and address of parson who completed causa of death (Item 23a) (Type, Print)

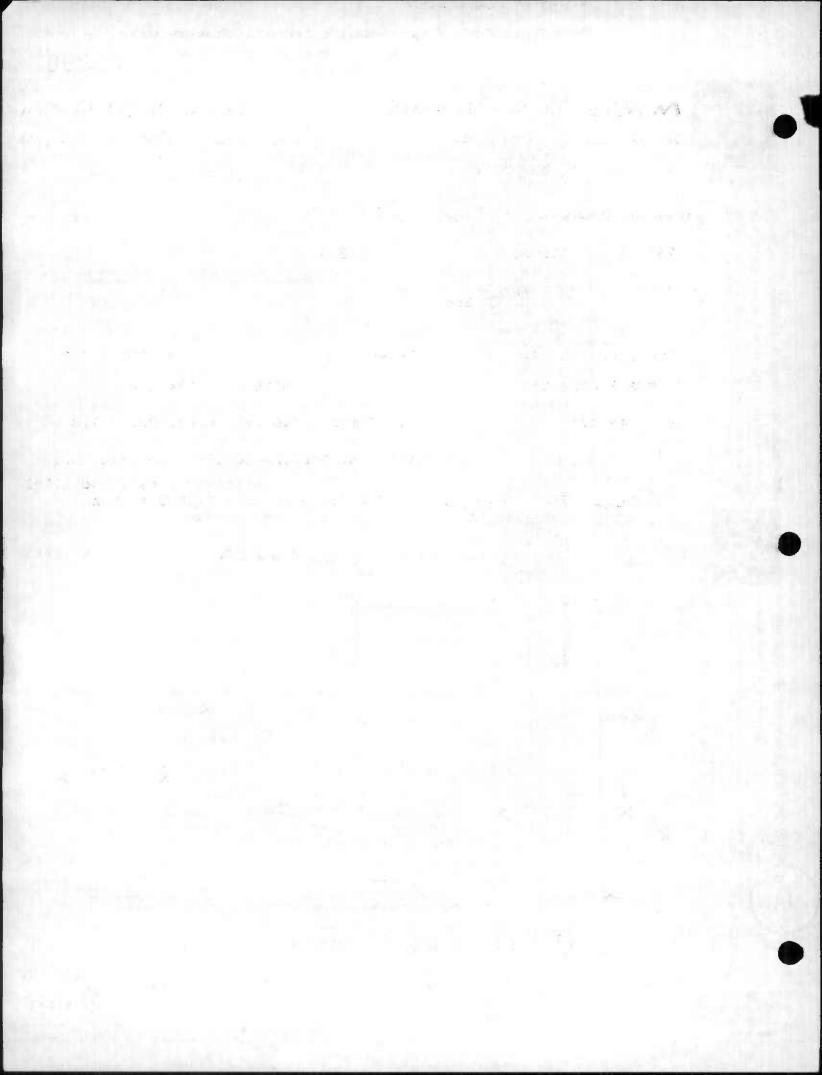
OCTOBER 11, 1941 GOO NORTH WOLFE ST.

DANIEL J. BROTMAN, M.D. TOWER 110 JOHNS HOPKING HOSPITAL

State Registrar

31. Data filad (Month, Day, Yaar)

32. Ragistrar's Signatura who Davidson Randell MD RIZET



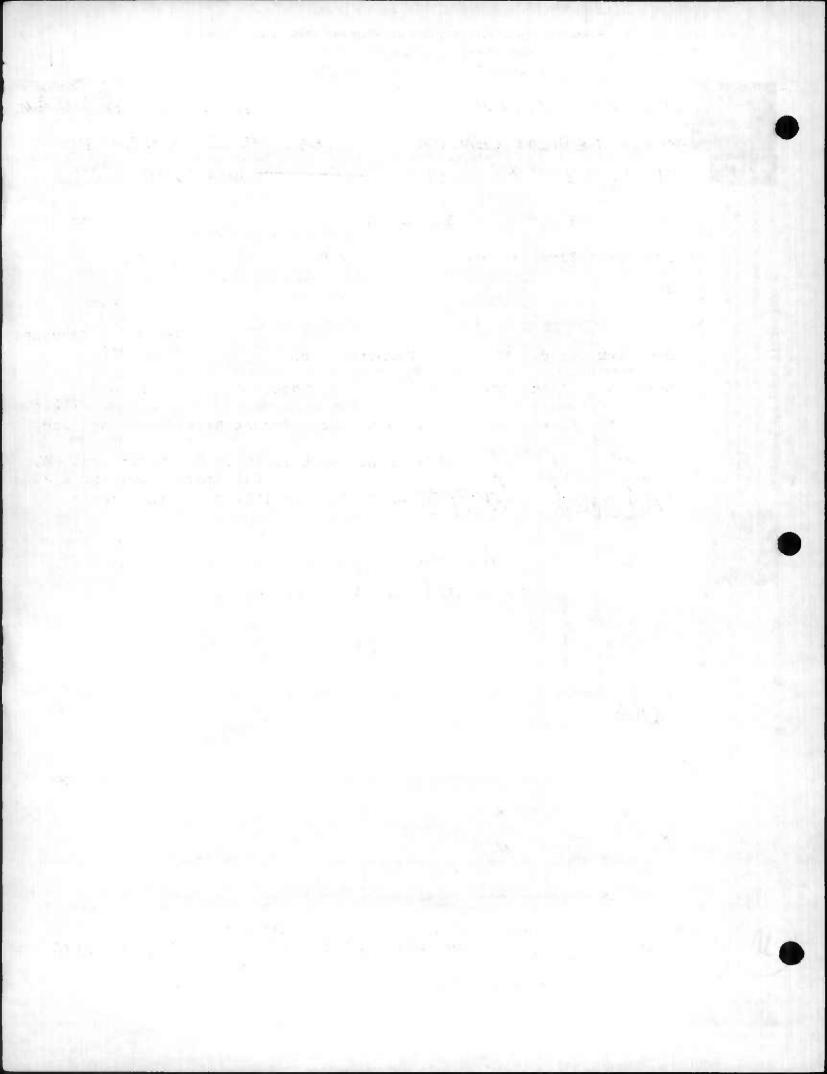
State of Maryland / Department of Health and Mental Hygiene Q 7 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician ALLEN 3:36 AM MARSHA OCTOBER 10 /Medical 4a. Facility Name (If not Institution, give street and number, 4b. City. Town, or Location of Deeth 4c. County of Death Examiner MERCY BALTIMORE
If Under 1 Year If Under 24 Hrs. 8. Dete of 8
Montha Daya Hours Min. (Month, C MEDICAL CENTER BALTIMORE 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Montha 1□ M 2 F 219-19-0378 9 464ST 5,1978 Yrs. Director Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Magical Examiner must be notified at 1□Yes 2□No Director Md. NA Baltimore 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 1725 East 33rd. Street 21218 USA Funeral death 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 la marked other than "natural", or ite 1 ☐ Yes 2/ No If Yes, Give Year or Dates: Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Uaual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Exclusive Personal Etementery/Secondery (0-12) College (1-4or 5+) Touch Salon High Sch. Grad. Cosmotogogist 17. Fether'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Dale A. Allen, Theresa Sharpe 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Addresa (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 permit. Pages 1 and 2 Department of Health a Important: If item 27 is Dale A. Allen 1725 E. 33rd. Street Baltimore, Maryland other altimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) eny injury or c 4 | Donation Greenmount Cemetery 10-11-97 Baltimore, Md. 21. Signety e of Funeral Service License 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.MArch CH 1101 E. Nroth Avenue Saul: Enter the discase, or complications that church shock, or heert feilure. List only one ceuse on each line. Do not enter the mode of dving, such ea cardiac or resolratory errest. Approximete Interval Between Onset and Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) quemia Examiner Due to (or es e consequence of): Examiner alcer Gastriz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and the burisi-trar Due to (or es a consequence of) physician Box 68760 Physician/Medical Due to (or es e consequence of) 8 attending ď detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. P.O. 23b. Did tobacco usa contributa to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown þ Division of Vital Records, 2 24b. Were eutopay findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed 17 page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 No actor. 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) 8 Hospital: 1 Sinpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yea 2 No 94 27. Manner of Death 28e. Dete of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Sulcide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(a) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(a) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifier Geneval Surgary 29c. License number D46064 29d. Date signed (Month, Dey, Year) auturally of Resident October 10, edical Mary land th 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Danhauser-Brun, Mil. herry medical -hu&toan 31. Date filed (Month, Dey, Year)
OCT 141 32. Registrar's Signeture

whia Davidson-Randoll

State Registrar

14199



Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: if item 27 is marked other than "netural", or items 23a or 28±4 show any injury or other traumetic event, the Mental Hygiene.  The marked other than "netural" or items 23a or 28±4 show any injury or other traumetic event, the Mental Examinet cannot be notified at a part of the mental or items 23a or 28±4 show any injury or other traumetic event, the Mental Examinet cannot be notified at a part of the mental or items 23a or 28±4 show and injury or other traumetic event, the Mental Examinet cannot be notified at a part of the mental or items 23a or 28±4 show and injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event, the Mental Examinet cannot be not injury or other traumetic event cannot be not injury or other traumetic event cannot be not injury or other traumetic event cannot be not injury or other traumetic event cannot be not injury or other traumetic event cannot be not injury or other traumetic event cannot be not injury or other traumetic event cannot be not injury or other traumetic event cannot be not injury or other traumetic event cannot be not injury or other traumetic event cannot be not injury or o	S. Social Secutive Number 6. Sec. Sec. Sec. Sec. Sec. Sec. Sec. Sec	street end number)  A A Age (In yrs.  A Age (In yrs.  A 10c. CI  A	Yrs. Mont  Ity, Town or Location  B G H  Ity, Town or Location  B G H  Ity, Town or Location  B G H  Ity, Town or Location  Ity, Town or	der 1 Year If Under 24 H hs Days Hours M  Da	(Specify Yes or Noerlo Rican, etc.)  lame (First, Middle, Me.  E (UNKNOWN  Rural Route Number, C  AVEBAL  Date  10-17-97  Elizabeth  ROE STB.	12 / 4c. County of N / A N / A N / A Pace - Black, Specify: b. Kind of Busin TRUCKI iden Sumeme) City or Town, Ste TO., M C. Location - Cit OWIN L. Ph ALTO.,	Birthplace (State or F Country)  S. CAROL:  10d. Inside City 11 Pres 2  at Country?  S. American Indian, White, etc.  BLACK less/Industry  NG  ate, Zip Code)  D 21216 yor Town, State  GS MILLS  illips
Examiner  To Be Completed by Funeral Director  To Be Completed by Funeral Director  To Be Completed by Funeral Director	Social Security Number  6. Sec. Social Security Number  6. Sec. Sec. Sec. Sec. Sec. Sec. Sec. Sec	10c. Cl	Assi birthday)  If Ur Mont  Ity, Town or Location  A Jen Jen Jen Jen Jen Jen Jen Jen Jen Jen	der 1 Year If Under 24 H hs Days Hours M  Da	(Specify Yes or Noerlo Rican, etc.)  lame (First, Middle, Me.  E (UNKNOWN  Rural Route Number, C  AVEBAL  Date  10-17-97  Elizabeth  ROE STB,	N/A  (Sear) 1920  1. Citizen of What  I. Citizen of What  I. Race - Black, Specify:  b. Kind of Busin  TRUCKI iden Sumeme)  City or Town, Sta  TO., M  C. Location - Cit  OWIN  L. Ph  ALTO.,	Birthplace (State or F Country)  S. CAROL:  10d. Inside City Interes 2  at Country?  S. American Indian, White, etc.  BLACK  BLACK  ate, Zip Code)  D 21216  yor Town, State  GS MILLS  illips  MD 212  Approximate interval Between
Department of Health and Mental Hygiens.  Department of Health and Mental Hygiens.  Department of Health and Mental Hygiens.  Department of Health and Mental Hygiens.  Important: If frem 271s marked other than "natural", or thems 23a or 28a-f show any Injury or other traumatic event, the Meanral Examiner must be notified at 27 show any Injury or other traumatic event, the Meanral Examiner and Section 1. Of 1. O	10e. Street and Number  10e. Street and Number  11. Marital Status  1 Never Merried 2 Married  3 Widowed 4 XDivorced  15. Decedent's Educ (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify)  17. Father's Name (First, Middle, Last)  NATHANIEL AL  19a. Informant's Name/Relationship (Ty)  EDWARD ALSTON  20a. Method of Disposition  1 Buriel 2 Cremation 3 Relationship (Specify)  21. Signature of Funeral Service License (Specify)  22a. Pert1. Enter the disease, or complication of the complete of the compl	A  Vedere G  12. Was Decedent Ever in U Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:  Coation e completed)  College (1-4or 5+) - 0 -  LSTON  The Point of the Complete of the Co	B G H.  101.  102.  103. Was De If Yes, s 1	Zip Code  2 12 15  Recedent of Hispanic Origin?  Recedent of Hispanic Origin?  Recedent of Hispanic Origin?  Recedent of Hispanic Origin?  Recedent of Hispanic Origin?  Recedent of Hispanic Origin?  RECEDENT OF THE Name of Or other place)  REST VET.  Recedent of Hispanic Origin?  RECEDENT OF THE Name of Or other place)  REST VET.  Recedent of Hispanic Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?  RECEDENT OF THE Name of Origin?	(Specify Yes or No- erto Rican, etc.)  working  lame (First, Middle, Me. E (UNKNOWN  Rural Route Number, C  AVE - BAL  Date  20 10-17-97  Elizabeth  ROE STB.	14. Race - Black, Specify: b. Kind of Busin TRUCKI iden Sumeme) ) City or Town, Ste TO., M c. Location - Cit OWIN L. Ph ALTO.,	at Country?  S.  American Indian, White, etc.  BLACK less/Industry  NG  Inte, Zip Code)  D 21216 yor Town, State  GS MILLS  illips MD 212  Approximate interval Between
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Examiner Examiner	Immediate Cause (Final disease or condition	ications that caused the deather cause on each line.					Approximate interval Between
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Ch 40	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		or es a consequence o	or):			
detached detached	Part II. Other significant conditions cont	stributing to death but not res	ulting In the underlyIn	g cause given In Part I.			bute to the cause of d
page 2 should be completed by	ASWO				24a. Was an e performed		4b. Were autopsy find eveileble prior to completion of caus ot deeth?
Com	Bremin				1□ Yes	2 No	1 ☐ Yes 2 ☐ No
9 0	25. Was case reterred to medical examiner?  1  Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Other	eath (Check only one) Home 5□ Besidence	e 6 DOther /	Specify)
flon:	7. Manner of Death  1 Natural 5 Pending Investigation		Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred				
74 E SE	3 Suicide 4 HomIcide  See. Certifier  10 Certifying Physics	28e. Place of Injury - At he building, etc. (Specification)	(γ)		City or Town, S	State)	or Rural Route Number
Parent of District	(Check only one)	sician: To the best ot my kno ner: On the basis ot examina end manner stated.	tion and/or Investigat	ed at the time, dete and platon, in my opinion, death oc	ce, and due to the ceus curred et the time, dete	se(s) end manne and place, and	or as steted.  due to the ceuse(a)
22 TO 1 400	9b. Signature and title of certifier			29c. License number	29d.		fonth, Day, Year)
1 3	0. Name, and address of person who con	The ted cause of deeth (Item	1)	027369		(0/13/	47

Britis - who reduced by the MELECULAR CONTRACTOR CONTRACTOR William D. D., N. H. L. D. T. T. C. C. TON THE could have touch feeling a substitute Lune 6 (L estine boose contra Miles to the same is the first

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Arscott 530p Doris October /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore Baltimore 5. Social Sacurify Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. Birthplaca (State or Foreign Country) **Funeral** 1□ M 2□ F Director 212-26-5620 DEC 30, 1928 Maryland Usual Rasidance of Decedant the Maryland 10a State 10h County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Medical Examiner mist be notiled at MD N/A M☐ Yas 2☐ No Director Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1435 Medfield 21211 Avenue Funeral USA 12. Was Decedant Evar in U,S. Armad Forcas?

1 Yas 2 No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Bleck, Whita, atc. 72 hours after 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify þ Specify: White 3 Widowed 4 Divorcad Completed 18a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b, Kind of Businass/Industry pemit. Peges 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) 12 Security Officer Security Agency 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be William Griffin Mabel Durham 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Arscott/son 3623 Greenvale Rd. Baltimore, MD 21229 20a. Mathod of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ♥ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/10/97 Baltimore, MD 22. Name and Address of Facility
Cremation Society of Maryland, Inc. 21. Signature of Funeral Service olen Edward A. Greebrchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daath **Physician** /Medical Hypertension Immediata Causa (Final Pulmonary diseasa or condition resulting in death) Examiner bunal-transit Sequantially list conditions, if any, leading to immadiate causa. Entar Underlying Causa (Disaasa or Injury that Initiatad avants rasulting In death) Last and Dua to (or as a consequence of): Box 68760. physician 9 Physician/Medical the Dua to (or as a consequance of): 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. ate has been signed by page 2 should be detact 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? certificate has 1 Yas 2 No 1 ☐ Yas 28 No Division of Vital Be 25. Was casa raferred to medical 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 10 1 Yas 2 No 1 Department 2 ER/Outpatient 3 DOA Director: After this 27. Mannar of Daath 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.

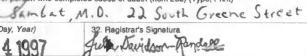
To the Funeral Director; After 5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 ☐ Homleide 29a. Cartifiai \*\*Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) Medical and manner statad. 29b. Signature and the of 29d. Data signed (Month, Day, Year) 29c. License number

State

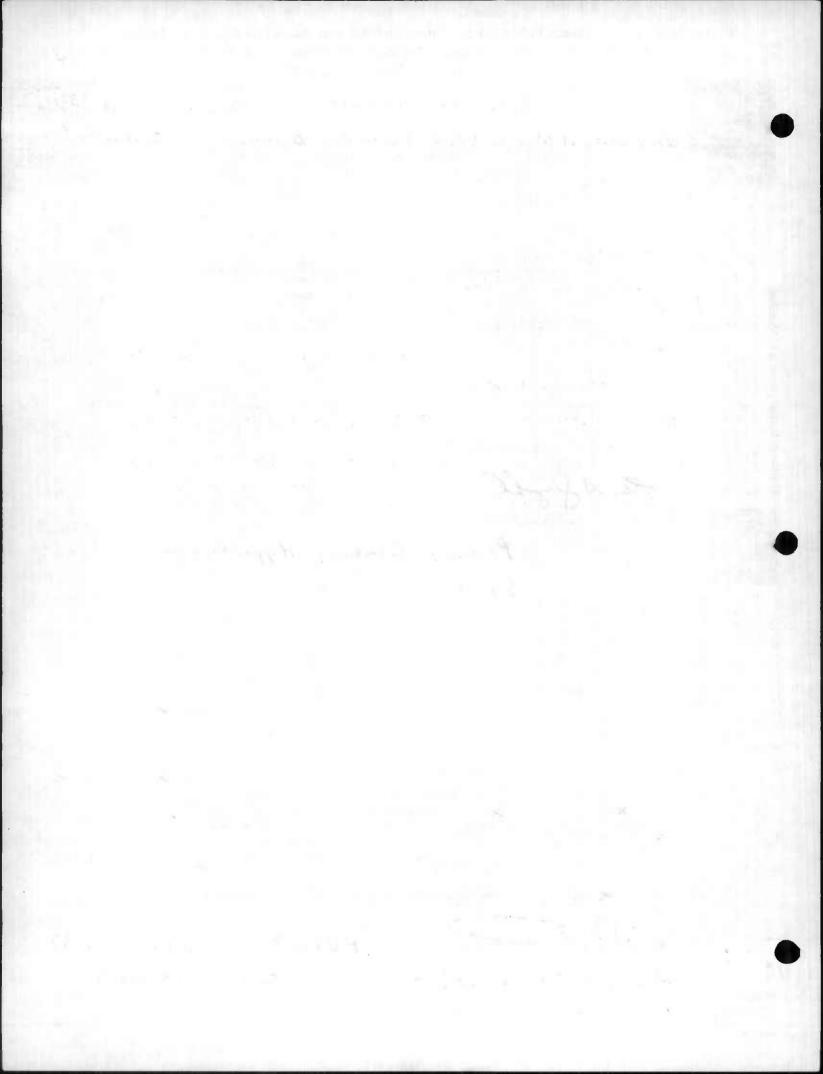
31. Date filed (Month, Day, Year) **0CT 1.4 1007** 

Michael



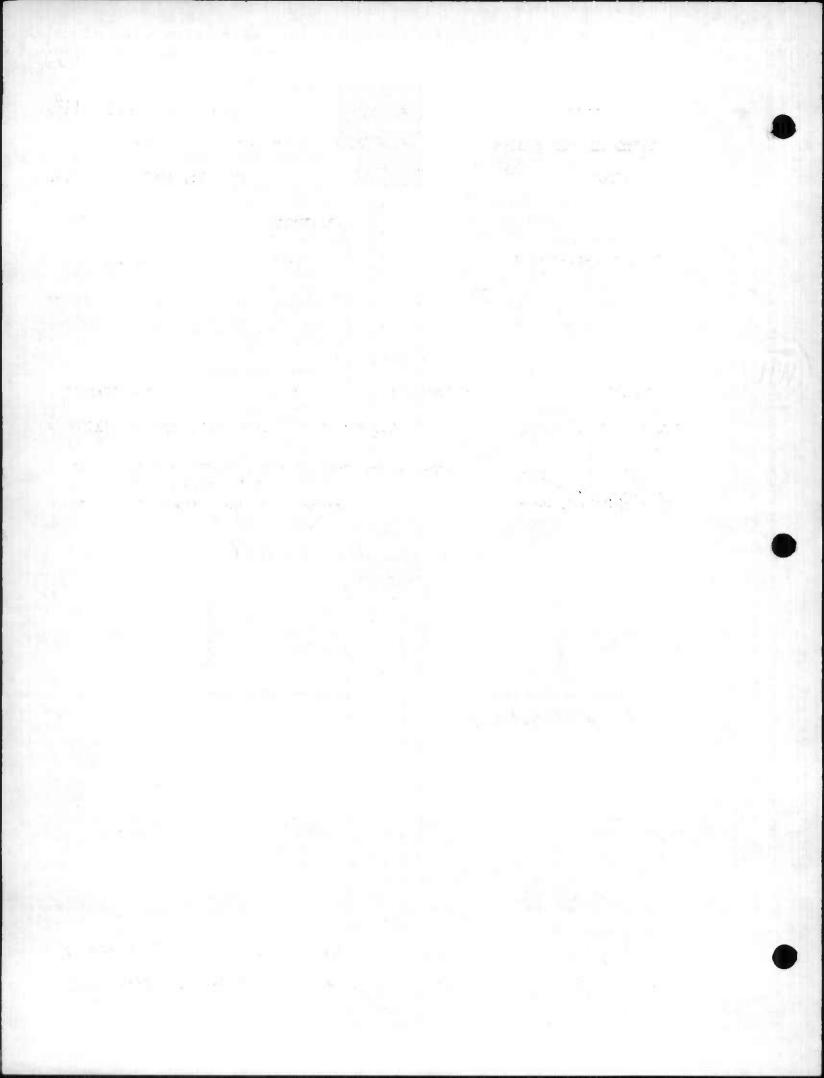
Baltimore MD 21201

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 9 7 3

San Service		1. Decedant's Nama (First, Middle, Last)							2. Date of Dea			3. Tima of D	eath
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		LEVINDALE H	HERREW HOME	7				BALTIMO	<b>२</b> ह	N/	Δ		
Funeral		5. Social Security Number	8. Sax	7. Age (In yrs.	last birthday)	If Under 1		If Undar 24 Hrs.				piaca (Stata or F	Foreign
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020 un afte ef. or ft	by Funeral	11. Marital Status  1 Nevar Married 2	Armed 1 ☐ Yas	12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas ②YNo If Yes, Give Yaar or Dates:		13. Was Decedent of Hispanic Origin? (Specify Y If Yas, apecify Cuban, Mexican, Puerto Rican  1 ☐ Yes 2 ☆ No Specify:			pecify Yas or No- Pican, atc.)	Specify	k, Whita,	etc. WHITE	
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W San	Comp	Elementary/Secondery (0-	12) College	(1-4or 5+)		MSTRE				CLOTHIN	G		
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altim mit. Pa partmen portant y injury se.		21. Signatured Funeral Service Learnine RODFE ZEDEK CONGREGATION 10/12/97 BALTIMORE, 22. Nama and Address of Facility Sol Levinson & Bros.,											
B Page B		22. Nama and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 2120											
		23a. Part1. Enter the disease shock, or heart failura.	e, or complications that	t caused the dear	th. Do not ant	er tha mode	of dylr	ng, such as cardiac	or raspiratory ar	rest,	e, m	Approximate	
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/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Cerebrel Phrombosis											V
		resulting in death)	a	Due to (	or as a conseq	ruence of):	,						
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E 0 6	edicai	resulting in death) Last		Due to (d	or as a conseq	uence of):							
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death death	100	Part II. Other significant con	dittons contributing to	death but not res	sulting in the ur	nderfylnn ceu	se ni	ven in Part I	23b. Did t	obacco use co	ntribute t	the cause of	death?
es that the digned by the	/ Physician/M		selezoh:		4		_	1.		/ee 2□ No		bably 4 Duf	
Vital Records, P.O. Box idean: The law requires that the death cercertificate has been signed by the attendin rector, page 2 should be deteched for use	Completed by	-					2		24a. Was i	an autopsy med?	av co	ere autopsy find allable prior fo impletion of cau death?	
The lay ate has page 2	E								1 D Y	as 20No	10	☐Yes 2☐No	0
Vital I	Be	25. Was cese referred to me examinar?	dical					26. Place of Dea	th (Check only o	ne)			
y V	0	1 Yes 2 No	Hospitai: 1 C	Inpatient 2	ER/Outpatien	t 3 DOA	Oth	ner: 4 13-1 Nursing He	ome 5 Resid	ence 6 Oth	er (Specif	(y)	
on of other the funera		27. Manper of Deeth  1 Natural 5 Pe 2 Accident inv		e of fnjury onth, Day Year)	28b. Time of Injury	28d	. Injui Woi 1 🔲	ry at rk? Yes 2 □ No	28d. Describe h	ow injury occur	red		
Division of Vita within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Co	uid not be termined 28e. Pla buil	ce of Injury - At h Iding, etc. (Specif	ome, farm, str	eet, factory, o	office		28f. Location (S City or Tow	itreet and Numb n, State)	er or Rura	al Route Numbe	or.
Hospi 24 hours Funer stely fill	edicai	29a. Certifier 1 Certicological Check only cone)	ifying Physician: To the loaf Examiner: On the	he best of my kno basis of examina anner stated.	owledge, death ation and/or inv	occurred at astigation, in	the tir	me, date and place, ppinion, death occur	and dua fo the cred at fhe tima, c	euse(s) and ma late and place,	nner as s and due to	taled. the ceuse(s)	
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FSFO		Meya	ni. pl	your	ii		34	14817					
9		30. Name and address of per	son who completed ca	use of death (Iter	m 23a) (Type,	Print)	1	14817 redere	ane	Ball	in	031	
State	e	31. Data filed (Month, Day, Y		Adderar Signi	ature 7	y) c		orce		, - ·			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 2. Date of Daeth Month 3. Time of Death **BERG** Day

October

10, 1997

3:55 p.m.

1. Decedant's Nama (First, Middla, Last) MARGOT Ι. **Physician** /Medical Examine **Funeral** Director permit. Pages 1 end 2 should be filed within 72 hours effer death with the Maryland Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0020

Physician /Medical Examiner

attending physician and i for use as the buriel-transit Medical Certification:

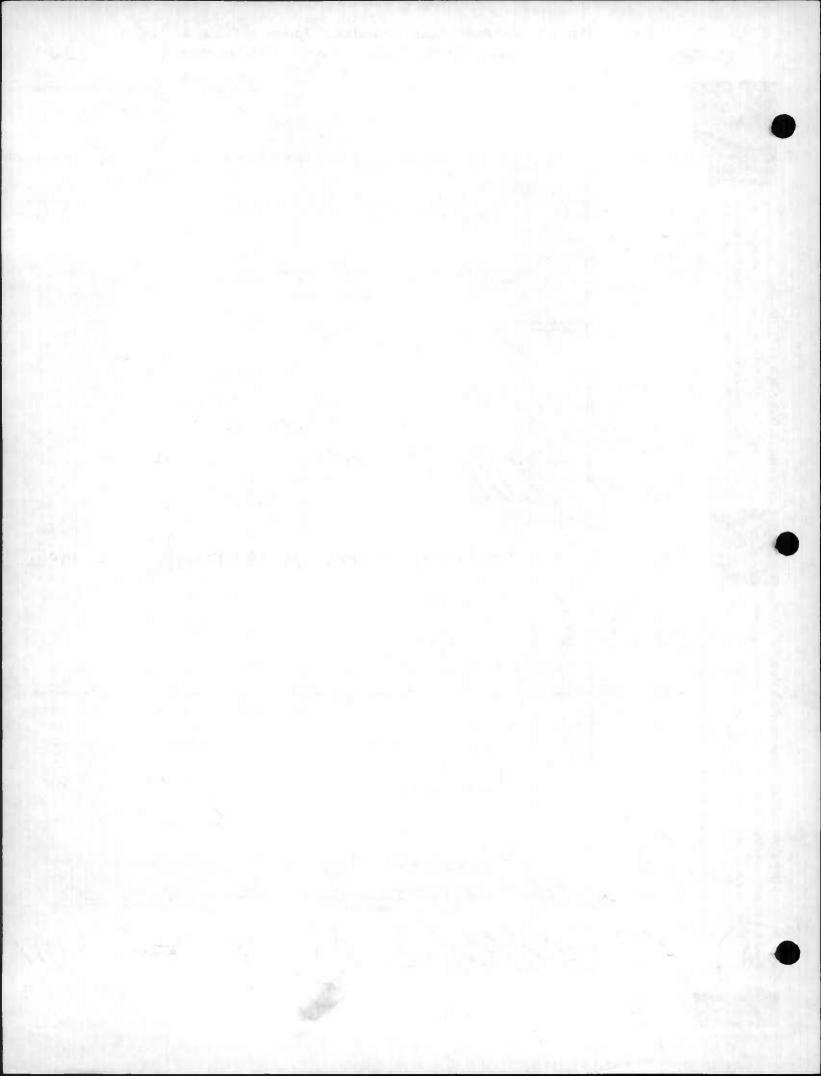
To he Hospital or Attending Physician: The law requiras that the death certificate be executed with a 44 hours effect death.

To the Funeral Director: After this certificate has been signed by the attending physician end come a funeral filled in by the funeral director, page 2 should be detached for use as the bundel transit Division of Vital Records, P.O. Box 68760,

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MD .	A.A.			PASADEN								1	0d. Insida City Limits 1 ☐ Yes 2 ☐ No
10e. Street and N	umber				10f. Zip	Coda				10g. Citiza	an of Wh	hat Coun	try?
	th Stre		- d 4 5 1 - 1	10 10	211						USA		
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Jan	rest of	r complications that to only one cause on	v.		3111	Mor	intain	Roa	d, Pasa	adena,	MD	211	22 Approximata
rasulting in death		<b>6</b>		or as a conse	equance of):				ri for				
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rasulting in death)			Dua to (	or es e conse	equanca ot):								
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25. Was casa rafe axeminar?	rred to medica	ı I					26. Place	of Daath	h (Check only	ona)			
	KNO	Hospital: 1 🗆	Inpatiant 2	ER/Outpatle	ent 3 DC	DA Oti	har: 4 Nurs	sing Ho	ma 5 Ras	Idanca 6	Othar	(Specify	1)
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3 ☐ Suicide 4 ☐ Homicida	6 Couid datam	nined 288. Place	of Injury - At hing, atc. (Spaci	nome, farm, st	treet, factor	y, office			28f. Location ( City or To	(Street and wn, Stata)	Num <i>ber</i>	r or Aura	l Routa Number,
29a. Cartifiar (Check only one)	1 Certifying 2 Medical	ng Physician: To the Examinar: On the b	best of my kno asis of axamina nar steted.	owledge, daa ation end/or Ir	th occurred	at tha ti	me, dete and opinion, death	place, a	and due to the ed at tha tima,	ceuse(s) e data and p	nd mani placa, en	nar es st nd dua to	ated. the causa(s)
29b. Signature an	d title of cartifla		nai stetet.	1	290	c. Lleans	sa number			29d. Data	signed	(Month I	Dev. Yearl
T		1/1/1	12/	1	,	1.	2/2	-	-/	1	-1	~	12 199-

32 Registrar's Signetura Julia Davidson-Randall

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Esther Olive Bryant 1997 OCTOBER 9:45 PM 10, 4e. Fecility Name (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Saint Joseph Medical Center Towson Baltimore 7. Aga (In yrs. lest birthday) | If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Annual A 5. Social Security Number 9. Birthplece (State or Foreign 1□M 20 F 218-26-6577 Maryland Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Co. Maryland Lutherville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 Wilderfield Court 21093-4758 United States 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11 Marttal Status Race - American Indien, Bleck, White, etc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White **¾**DWidowed 4 □ Divorced Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middla, Lest) 18. Mother's Name (First, Middle, Melden Sumema) Benjamin Blackstock Olive Scott 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda) Debbie Bryant (Daughter) 40 Lambeth Bridge Ct. Lutherville.Md. 21093-3953 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☑Burial 2 ☐ Cramation 3 ☐ Removel from Stata Parkwood Cemetery 10/14/97 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Jeffrey L. Gair 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Perff. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceum on each line. Onsat and Deeth Immediate Ceuse (Finel CEREBROVASCULAR ACCIDENT 3 WEEKS diseese or condition resulting in death) Due to (or es e consequence of) PNEUMONIA 3 WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Due to (or es a consequance of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION 24e. Wes en eutopsy performed? 24b. Were eutopsy findinga eveileble prior to DIABETES MELLITUS completion of causa of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes cese referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Menner of Deeth 28d. Describe how injury occurred

physician end the buriai-transit Box 68760 attending for use as P.O. signed by the a d be detached f Records, page 2 certificate Division of Vital Hospital or Attending Physician: director.

Physician

/Medical

Examiner

Director

Funeral

by

Completed

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

Hygiene.

Important: If item 27 is marked other 1 any injury or other traumatic event, It once.

Pages 1 and 2 should be and Mental

8

Physician /Medical

Examiner

Examiner Physician/Medical 9 Completed Be Certification: To efter death Director: A 3 in by the f

1 Naturel 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homlcide

(Check only one)

24 hours To the Hospi within 24 hou To the Funer completely fill

Pelli

After

death.

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

28e. Dete of tnjury (Month, Dey Year) 28b. Time of 28c. Injury et Work?

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

29b. Signature end title of clertifier meltano

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

D41410

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

JOGINDER P. MEHTA, M.D.

14 1997

5 Pending investigation

6 Could not be determined

7620 YORK ROAD

🛣 Certifying Phyetcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

TOWSON, MARYLAND 21204

31. Date fleet (Month, Day, Year) State Registrar

32. Registrer's Signetura

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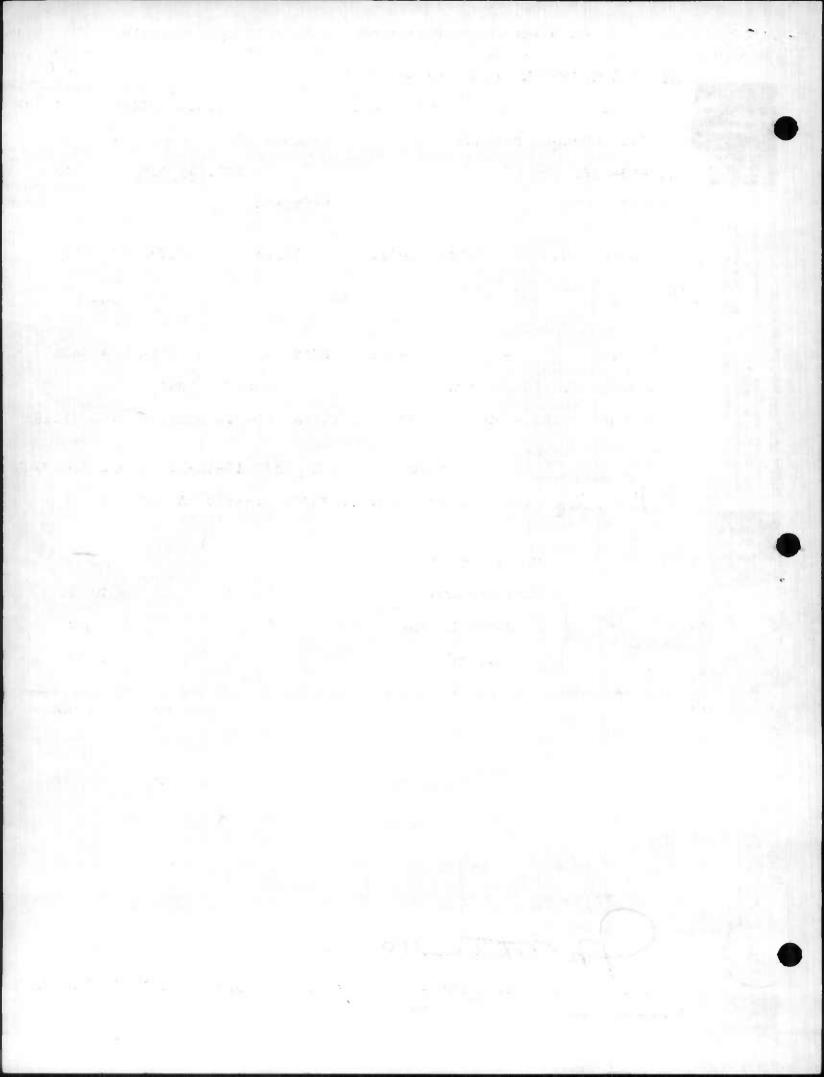
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State of Maryland / Department of Health and Mental Hygiene 7

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/Medic	al	HUBERT  4a. Facility Nama (If not Institution, give	VERDELL	BURKE		4b. City, Town, or L	1		
Examin	eı		EA TERRACE			BALTIM			na
uneral irector		5. Social Sacurity Number 6. St 217-38-8163 3 Usual Rasidanca of Decedant	ax 7. Aga (In	yrs. last birthda 57 Yrs.	Months Days	if Under 24 Hrs. Hours Min.	8. Data of Bir Month, Da JUL • 2	7, 1940	Birthplaca (Stata or Fore
28a-f show		10a. Stata MD 10b. County	na 100	c. City, Town or	Location E	ALTIMOR	E		10d. Insida City Lin
23a or 28	Funeral Director	10e. Street and Number 10f. Zip Coda 10g. Citizan of W 2200 CHELSEA TERRACE 2-fl. 21216 UNITED							STATES
elf, o	by	11. Marital Stetus  X X X Navar Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Wes Dacedant Ever in U,S Armed Forças 1 ☐ Yas X X No If Yes, Giva Yeer or Datas:		in U,S.	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2XXo		ecify Yes or No Rican, atc.)	Bleck, \ Specify:	American Indien, White, etc.
than "natur the Wedical	Completed	15. Decedent's Ed (Specify only highast graded) Elementery/Secondery (0-12)	ucation da complated) College (1-4or 5+)		cedant's Usual Occup va kind of work dona i. DO NOT usa retired IEAT PRO	eation during most of work d) OCESSOR	ing	16b. Kind of Busin	SAUSAGE
ave dott		17. Fathar's Nama (First, Middla, Last)		-			a (First, Middla,	Maidan Sumeme)	
	To	HUBERT V.	BURKE SR	•		MIL	DRED	EDWARDS	
27 is trau		19a. Informant's Name/Ralationship (Type, Print)  DWAYNE BURKE - SON  19b. Mailing Address (Street and Number or Rural Routa Number, City or Town 2200 CHELSEA TERR., BALTIMO  20a. Mathod of Disposition  20b. Place of Disposition (Nama of Data 20c. Location							
important: if Item any injury or other once.		1	Ramoval from Stata	ss of Fecility	10-15		DALLSTOWN		
esician edical		23a. Part 1. Enter the disease, or comp shock, or heer feilure. List only of Immediate Causa (Final disease or condition	one cause on each lina.			IARCHFH .			APPROXIMETE INTERVEL BATTER ONSAL AND DEATH
miner		resulting in death)	Cardiac Arr	to (or es e cons	sequence of):				
t s	Examiner		Cardiomyopa	ther					
al-tran	ă	Sequentially list conditions, if any, leading to immediate	Dua	to (or as a cons					20 yrs
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State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Deeth Day 1997 Month **Physician** BRADFORD DONALD OCTOBER 5:27p /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** BALTIMORE CITY
ar If Undar 24 Hrs. 8. Deta of Birth HOPKINS HOSPITA THE JOHNS N/A If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Birthpieca (State or Foreign Country) **Funeral** 1 M 2□ F Months Deys Hours 212-39-9780 Director Maryland Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23a or 28a-f show adical Examiner must be notified at Dundalk 1 Yas 2 No Maryland Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 1937 Barry Road death Funeral Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Bleck, Whita, etc. Peges 1 and 2 should be filed within 72 hours after or and of Heelin and Mentel Hygiene.
Int: If tem 27 is marked other than "naturel", or itel into or other traumatic svent, the Medical Engine 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detas: 1

✓ Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2♥ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) N/A N/A Student 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Surname) Be Donald Lloyd Bradford, Jr. Deneane Linzeu 19e. Informent's Neme/Relationship (Type, Print) Parents 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr. & Mrs. Donald Bradford, Jr. 1937 Barry Road Dundalk, Maryland 21222 20b. Pleca of Disposition (Name of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Steta Burial 2 Crametion 3 Removal from State permit. Pege Depertment of Important: If any Injury or 4 ☐ Donetlon 5 ☐ Other (Specify) Sacred Heart of Jesus Cem. 10/13/97 Dundalk, Maryland 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Pert1. Entar tha disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

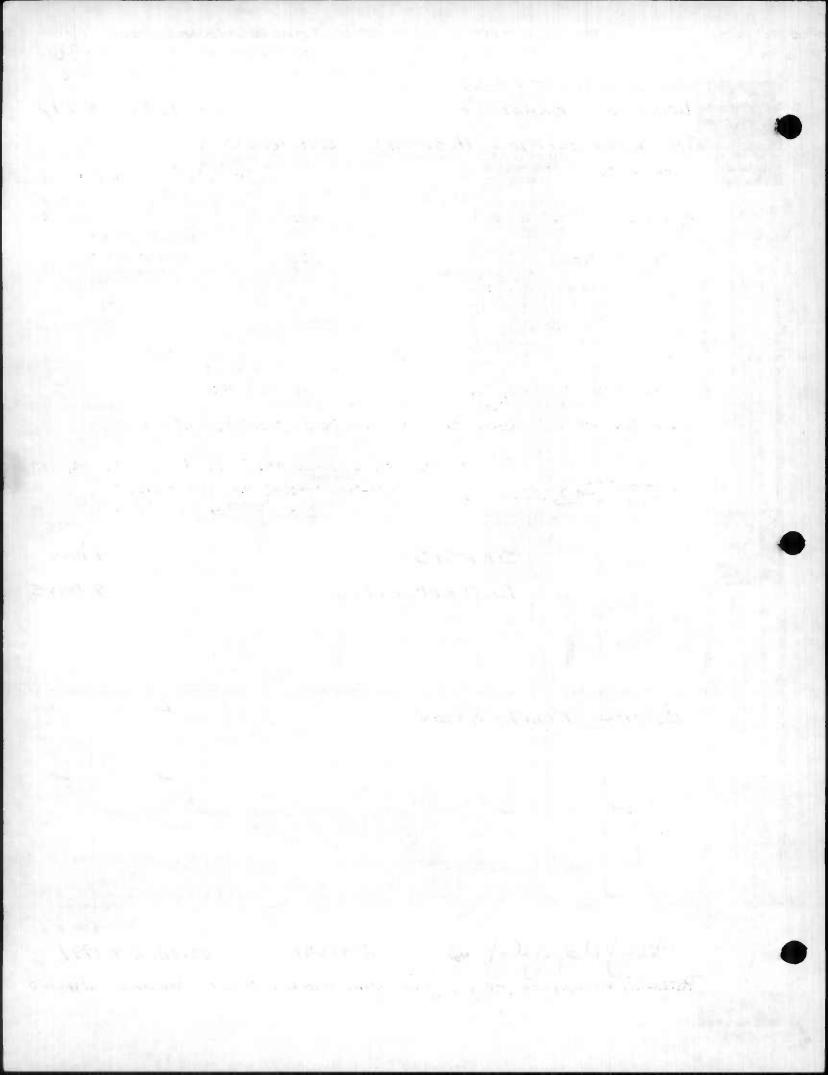
Approx.

Approx. Approximete Interval Between Onset and Deeth Physician /Medical Immediete Ceusa (Final SEPSIS disease or condition resulting in deeth) Examiner Examiner =NTEROCOLITIS The lew requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leeding to Immadiate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): physician s the buriel P.O. Box 68760. Physician/Medical Dua to (or as e consequenca of): ettending pl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown ECFERATION ate hes been signed page 2 should be de Records, þ 24b. Were autopsy findings aveileble prior to completion of causa of deeth? Completed 24a. Wes en eutopsy performed? 1 Yes 2 100 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yas 211 No Certification: To this filled in by the funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Neturel 5 Pending investigation within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. 29a. Certifier Medical (Check only one) ro the 29b. Signeture end title of certifier 29c. Licanse numbar 29d. Date signed (Month, Dey, Year) 45651 OCTOBER 9, 1997 of death (Item 23a) (Type, Print) 1 the son JOHNS HOPKENS HOSPITAL BACTIMON MARKAND 31. Data filad (Month 32 State

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene() Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08-10 An 4a. Facility Name (If not institution, give street and number) Suppir Ottopie 4b. City, Town, or Location of Death 132/7 imars 5. Social Sacurity Number 6. Sax Hours Min. 8. Date of Birth (Month, Dey, Year) JULY 7, 1939 WORTH CAROLINA Locate City Limits lorpital Randall ston If Undar 1 Yaar 7. Age in yrs. lest birthday) Months Days 241-68-5870 1□M 2XF Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No MARYLAND KANDALLSTOWN BALTIMORE 10e. Street and Number 10g. Citizen of What Country? CEDARHILL KOAD 2 1133 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yas 2 No If Yes, Give 1 Yes 2 No Specify. Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND MA DEGREE NURSE - DIRECTOR 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) BROWN BROWN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) RUSH L. BEAMAN (HUSBAND) (33 CEDARHILL ROAD, RANDALLSTOWN MD. 21133 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cramation 3 □ Removal from Stata KING MEMORIAL PARK 10-13-97 WOODLAWN, HARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Addrass of Facility 23. Name and Addrass of Facility 24. BROWN JR. FUNERAL Home 25. Name and Addrass of Facility 26. BROWN JR. FUNERAL Home 27. Name and Addrass of Facility 28. Name and Addrass of Facility 29. Name and Addrass of Facility 29. Name and Addrass of Facility 29. Name and Addrass of Facility 21. Signature of Funeral Servica Licansee 21. Name and Addrass of Facility 22. Name and Addrass of Facility 23. Name and Addrass of Facility 24. Name and Addrass of Facility 25. Name and Addrass of Facility 26. Sept. H. BROWN JR. FUNERAL Home 27. Name and Addrass of Facility 28. Name and Addrass of Facility 29. Name and Addrass of Facility 29. Name and Addrass of Facility 29. Name and Addrass of Facility 21. Signature of Funeral Servica Licansee 21. Name and Addrass of Facility 22. Name and Addrass of Facility 29. Name and Addrass of Facility 29. Name and Addrass of Facility 20. Name and Addrass of Facility 21. Signature of Funeral Servica Licansee 21. Name and Addrass of Facility 22. Name and Addrass of Facility 23. Name and Addrass of Facility 24. Signature of Funeral Servica Licansee 29. Signature of Funeral Servica Lica Immediate Cause (Final · Adult respiratory distress syndrome unknown disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24a. Wes an autopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death? 1 res 2 No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatiant 2 EP/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28b. Time of

**Physiclan** /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

p

Director

the Maryland

permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Manylan Department of Haelih and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any Injury or other traumatic event, the Manical Expuries may be notified as any Injury or other traumatic event, the Manical Expuries may be notified as

Baltimore,

sician and burial-transit physician s tha burial Box 68760. Records, P.O.

Physician/Medical

þ

Completed

Be

Certification:

Medical

Division of Vital Hospital or Attending Physician: hours after death. in by tha funaral JA

Registrar

State

iones

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signatura and title of cartifiar

31. Date-filed (Month, Day, Yeer)

14 1997

5 Pending invastigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

28d. Describe how injury occurred

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)

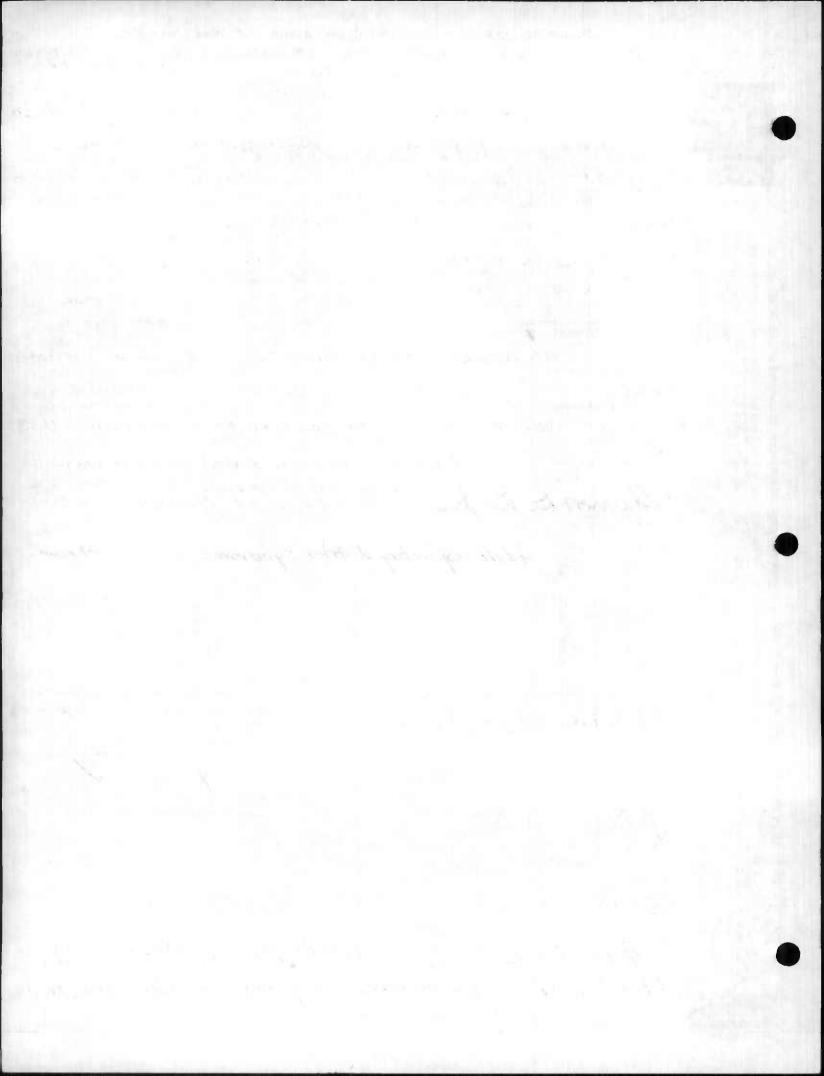
10 Certifying Physician: To the best of my knowladge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licanse number 29d. Data signed (Month, Dey, Year)

1-12 pp; Tal Randallitum mD

North West Julia Auridson 32. Registrer's Signeture

**DHMH 16 Rev 6/95** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 1 3 0 8 0 0

				Certificate	of Death		Reg. No.			
nysician	Decedant's Nama (First, Middle,	Last)			2. Date of De Month	ath Day	3. Ti	ma of Deeth		
/Medical	Katherine		Oct. 1	L2, 1997		20 A.M.				
Examiner	4a. Facility Name (If not institution,		4b. City, Town, or Location of Death 4c. County of Death							
	Millennium Healt	h Care Cer	nter		Glen	Burnie	A	nne Arur	ndel	
neral ector	215-24-3931	Sex 7.1	Aga (In yrs. last bir 90	thday) If Under 1 Months	Year If Under 24 H Days Hours M	rs. 6. Data of Bir (Month, Da Aug. 1	th y, <i>Year)</i> , 1907	Year) 9. Birthplaca (State or For		
3	Usual Rasidance of Dacedant  10a. Stata 10b. County		10c. City, Town	or Location				10d los	ide City Limits	
ust be notified at	- Control of the cont								Yes 25 No	
I Dire	10e. Street and Number 6656 Roberts Ct.			10f. Zip 0			10g. Citizen of \	What Country? States		
event, the Medical Examiner must be nothed.  Be Completed by Funeral Director	11. Meritel Stetus  1 Nevar Married 2 Married	12. Was Decedar Armed Forca: 1	s? ≹No	13. Was Deceda If Yas, specif	nt of Hispanic Origin? Cuban, Maxican, Pu	(Specify Yes or No erto Rican, etc.)		e - Amarican Indi ck, Whita, atc.	an,	
ated i	15. Decedant's	Education		Decedent's Usual	Occupetion	vodrina	16b. Kind of B	White usiness/Industry		
Be Completed	Elamantary/Secondery (0-12)	College (1-4o	r 5+)	Homemak	done during most of w retired)	ional g	Ott	n Home		
Ü	17. Fethar's Neme (First, Middla, La	st)		nomemax		lama (First, Middla,				
To B	Albert O. Lopez	1			Kath	erine R. Cross				
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Evanine Frust be notified at once.  To Be Completed by Funeral Director	19a. Informant's Name/Ralationship	(Type, Print)	r Rural Routa Number, City or Town, State, Zip Code)							
	Carol Andercyk /	Daughter	77	35 Jones	Dr., Pasa	dena, Mar	yland 2	1122		
ry or oth	20a. Mathod of Disposition  1		8	Disposition (Nama y, crematory or oth ad Mem. P.		Oct. 15,		City or Town, Sta le, Mary		
any Inju	21. Signature of Funeral Service Li	ensee	1	22. Nema end Kirkley	Addrass of Facility -Ruddick F	uneral Ho	ome			
	, Acid othe	w			in Hwy. S.			7		
cian lical iner	23a. Part1. Entar tha disaesa, or co shock, or haart failura. List on Immediata Ceusa (Final diseasa or condition rasulting in death)			ry Diseas		as of rospitatory a		Intarvi Onset	ximele al Between and Death Years	
- E		Urmot		consequence of):				20 *	10275	
e die burer-vansir	Sequentially list conditions,	<b>в</b> . Нурос	hyroidisi Due to (or es a c	onsequance of):				20 3	years	
<u> </u>	Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury	C								
5	that initiated evants rasulting in death) Last	d	Dua to (or as e o	onsequance of):	of):					
etached for use Physician/	Part II. Other significant conditions		but not rasulting in	tha underlying cau	23b. Did	23b. Did tobacco use contribute to the cause of				
									3 Probably 4 Unknown	
Completed by			24a. Was an autopsy performed?			24b. Wara autopsy findings available prior to completion of cause of death?				
Com						10	Yes 210 No	1 🗆 Yas	2 No	
Be C	25. Was casa rafarred to medical				26. Place of D	eath (Check only o	nne)			
2	examinar? 1 ☐ Yas 2 ☐ No	Hospitel: 1 ☐ Inpa	tlent 2 ER/Ou	tpatient 3 DOA	Other:	Homa 5 Rasio		ar (Specify)		
funera tion:	27. Mannar of Death  1 Netural 5 Panding 2 Accidant invastigat	28a. Data of In (Month, E	4141			26d. Dascribe	how injury occur	red		
à = 1	3 ☐ Sulcida 6 ☐ Could not 4 ☐ Homicida datarmine	office								
completely filled in by the	29e. Certifier 1 Certifying I (Check only one)	Physician: To the bes aminer: On the basis and mennar:	of examinetion and	deeth occurred at Vor invastigation, in	tha tima, date and ple my opinion, daath oc	ce, and dua to the curred at tha tima,	causa(s) and ma data and place,	nner as steted. and due to tha ca	use(s)	
Me Me	29b. Signature and title of certifier	1:	0	29c. l	icansa number		29d. Data signe	d (Month, Day, Ye	ear)	
	1 stars	war	M.	De	14160		October 13, 1997			
,	30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)									
-	30. Nama and addrass of person wh Harjit Singh, M.				rookless D-	wele Manne-7	222 21	225		

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate of	Death		Reg. No.	01	0001	
Physicia	n	1. Decedent's Name (First, Middle, La		7.1				2. Date of De Month	ath Dey	Year	3. Time of Death	
/Medica	_	GOLENA [		NW				CTOBE		997	1410 pm	
Examine	r	4a. Fecility Name (If not Institution, giv					4b. City, Town, or L		4c. County	of Death		
		51NA1 HOSPIT		3ALTII		If Under 1 Year	BALTIM If Under 24 Hrs.		h. I	1YA	lass (Onto as Familia	
uneral irector			M KAF	81	Yrs.	Months Deys		8. Date of Bin (Month, Da JUL - 2	y, Year) 2,1916	NOR'	lace (State or Foreign try) TH CAROL	
Mo to		10e. State 10b. County		10c. City, 7	Town or Loc	cation				1	0d. Inside City Limits	
28a-f show	Ö	MD	na		B	ALTIMOR	RE			1 X Yes 2 □ No		
0 8 6	al Director	4000 IELLOWWOOD ROAD apt 400							10g. Citizen of V UNITED		atry? ATES	
er, or items Examiner m	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Middowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Force 2 V Service 2 Married 3 Middowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Force 2 V Service 2 Married 1 Mexican, Pu 1 Yes, Sive Yeer or Dates:			(Specify Yes or No- erto Ricen, etc.)  14. Race- Black,  Specify:							
naturel' ofical Ex	g e	15. Decedent's Ed (Specify only highest gra	ducetion	1	16a. Deced	ent's Usual Occu	pation during most of work ed)	cina	16b. Kind of Bu	usiness/inc	dustry	
The M	Completed	Elementery/Secondary (0-12)	College (1-4or	5+)	CO		ed)	ung	A A	I C	ORP.	
importent: in teem 27 is marked other than any injury or other traumatic event, 17 a. M. once.  To Be Comp	a a	17. Father's Name (First, Middle, Last, CHARLES	FREEMAN				18. Mother's Nam		Maiden Suman RINGTO			
		19a. Informant's Name/Relationship (Type, Print)  GOLENA D. CRAWFORD 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code, 518 N. POTOMAC STREET, BALTIMORE, MD									MD 21205	
		20a. Method of Disposition 1XIXuriel 2 □ Cremation 3 □	Removal from State	റരണ	e of Dispos etery, crem	sition (Name of atory or other pla	ace)	Date	20c. Location -	City or To	own, State	
		4□Donation 5□Other (Specify)  BALTIMORE CEMETERY 10-13-97 BALTIMORE, MD										
		21. Signature of Fundral Service Licer	Marc	h		Name and Addr M. C. N	ess of Fecility MARCHF H	4300	WABA	SH	AVENUE	
		2 Part 1. Enter the disease, or com shock, or heart feilure. List only	plications that ceuse one ceuse on each li	d the death. I	Do not ente	or the mode of dy	Ing, such as cerdiac	or respiratory a	rrest,		Approximate Intervel Between Onset end Death	
in and interest the state of th		Immediate Cause (Final disease or condition resulting In death)	a. CORONA	RY A			SEASE				30 VEARS	
		BRIGHT ABOVE THE KNEE AMPUTATION									1 DAY	
		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury cause)									3 MONTHS	
	Medical	that initiated events presulting in death) Last Due to (or as a consequence of):									2 10 010 11115	
	Physician		d									
hed fo	SIC								23b. Did tobacco use contributs to the cause of de			
dateched									1 Yes 2 No 3 Probably			
8 3	Completed by	HYPERCHOLE				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			an autopsy rmed?	ava	ere autopsy findings ailable prior to mpletion of cause	
08 2 S	de				1.0				/		death?	
rector, page								10'	res 2 No	1 [	☐Yes 2☐No	
rector		25. Was cese referred to medicel examiner?	26. Plece of Death (Check only one)  Hospital: 10   Death (Check only one)									
uneral dire		1  Yes 2 No  27. Menner of Death  1 Natural 5  Pending	28a. Date of inju (Month, Da	ury 28	l/Outpatient Bb. Time of Injury	28c. Inju	iry at ork?		dence 6 Oth now Injury occur		γ)	
ed in by the funera	Ilicat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	9 28e. Place of In	jury - At home	e, farm, stre	M 1 E	Yes 2 No			per or Rura	I Route Number,	
in in	La C	4 LI Homicide	building, et	ic. (Specify)		(		City or To	vn, State)			
complately filled in by the funeral director,	egical	29e. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examination	dge, death end/or inv	occurred at the ti estigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and ma date and place,	anner as st and due to	tated. the ceuse(s)	
To the Funeral Director: Affer complately filled in by the fune	-	29b. Signature end title of certifier				29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)	
		1 Elen	Ula	Col	d	ASZH	0232211	ER 8586	OCTOR	SER	7 1997	
10		30. Name end eddress of person who	completed cause of o	deeth (Item 23	Be) (Type, F							
		ELIZABETH	ELAINE	REL	DD,	SINA	1 HOS	PITAL	~, B	ALT	O. MD	
State		31. Date filed (Month, Dey, Year)	22. Registr	rar's Signature	9							

Registrar

OCT 14 1997 Full Devidon-Rander

2/17/- 21

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM#19a FLM#G752 10/14/97 J.A. 1. Decedent's Name (First, Middle, Last, 2. Date of Deeth 3. Time of Death SHARON BERLIN 1120 AM OCTOBER 9,1997 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE BAUTIMORELITY HOSPITAL SINAI OF 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JULY 17, 1952 5. Sociel Security Number 6. Sex 9. Birthplace (Stete or Foreign Days 1□M 2√2 F MARYLAND 45 Yrs 213-48-4709 Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. inside City Limits BALTIMORE 1 ☐ Yes 2 ☑ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 RUTH EAGER CT. 21208 USA 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marltei Status Black. White, etc. 1€ Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) MEDICINE NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) **JACK** BERLIN AUDREY 19a. informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACK BERLINE (FATHER) 121 RUTH EAGER CT. BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State CHIZUK AMUNO (ARLINGTON) 10/10/97 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility SOL LEVINSON & BROS., INC. aye 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Approximete interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) ANOREXIA 20 VEARS Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Was an autopsy

**Physician** /Medical Examiner

physician and the burief-transit

for use as

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certificate

this funeral

After

death.

To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

director,

the

the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

or Attending Physician:

Examiner

Physician/Medical

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Completed

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Certification: To

Medicai

Department of Health a Important: If Item 27 is any injury or other tra

Pages

Baltimore, Maryland

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

**Director** 

28a-f show

8

or itsms 23a

Director

Funeral

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Completed

Be 10

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

25. Wes cese referred to medical exeminer? 1□ Yes 2No

26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes

28d. Describe how Injury occurred

27. Manner of Death Naturel 2 Accident 3 Suicide

4 Homloide

1 Inpatient 2 ER/Outpatient 3 DOA 5 Pending investigation 6 Could not be

28b. Time of 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

2 No

29a, Certifier (Check only one)

1 Cartifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

Keda no

AS2402321 ER8586 OCTOBER 9 1997

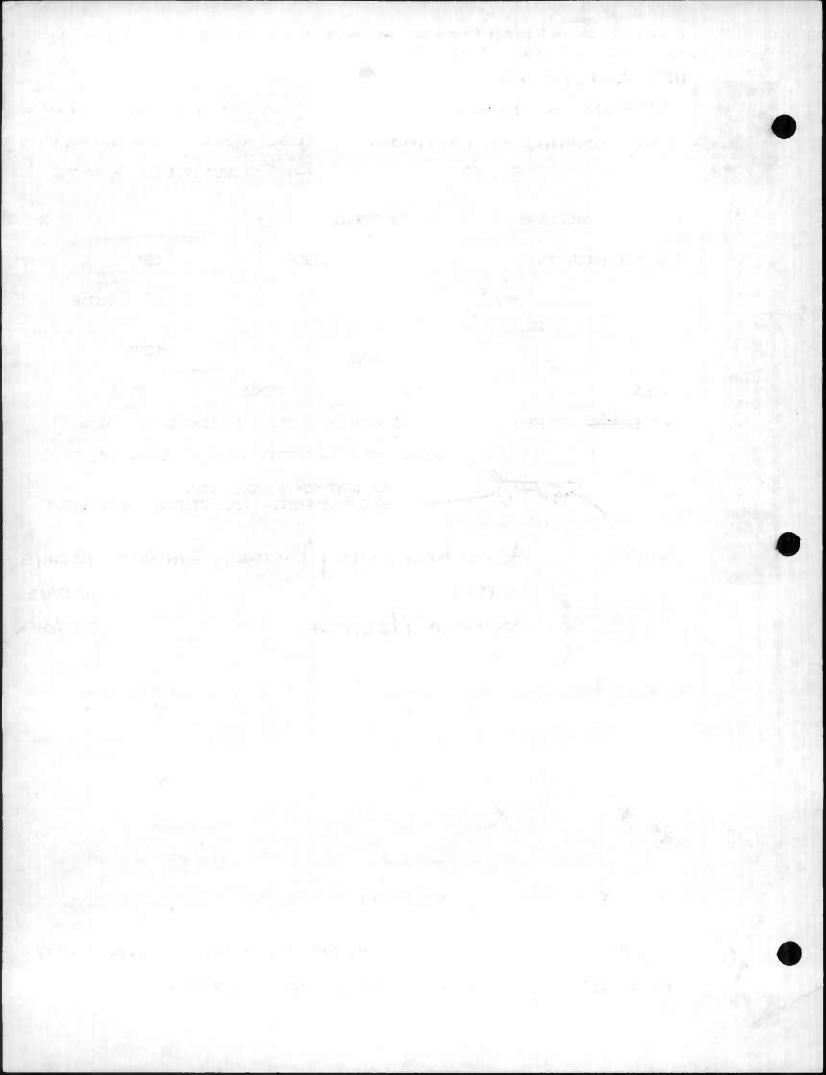
30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

REDD NO SINA ELAINE Julia Devidson-Randall

28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify)

State Registrar

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 8 per F.H. G-752 10/17/97 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6 OCTOBER, 1997 **Physician** 8:00PM BAUGH BETTY GERALDINE /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Saint Joseph Medical Center Towson 7. Age (In yrs. lest birthdey) If Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth 1 1 / 20 / 19 | 9. Birthplace (State or Foreign (Month, Dey, Year) | 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 🖾 F Yrs Director 162-16-3089 Nev 29, 1919 Pennsylvania Usual Residence of Decedent with the Merylence 10a. State 10c. City, Town or Location 10b. County 10d. fnside City Limits x 28a-f show 1 ☐ Yes 2 € No Director Maryland Baltimore Woodlawn 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be a 3101 Rheims Rd. 21244 Pages 1 end 2 should be filed within 72 hours after death nent of Health and Mentel Hygiena.
nt: If Item 27 Is marked other than "natural; or items 23. Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, 11. Marital Stetus Black, White, etc. 1 Never Married 2 Merrled 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Melden Sumeme) Be 2 Arley Elmer Walls Estella Vernetta Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) other t Mr. David Baugh (Son) 2214 Edenbrooke Ct. Sykesville, MD altimore. 20b. Place of Disposition (Name of cematary, cremetory or other piece) 20e. Method of Disposition Data 20c. Location - City or Town, State Department of Important: If it any injury or our once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Park Place Cemetery 10-10-97 Uniontown, Penn. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 19hy-8728 Liberty Rd. Randallstown, MD 21133 23a. Pa 17. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Between Onset and Death **Physician** /Medical ACUTE RENAL FAILURE Immediate Cause (Finei disease or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION physician and s the burial-trans Sequentially list conditions, if any, leading to Immediate ceuse. Entar Undarfying Cause (Diseese or Injury that initiated avents resulting in death) Last Due to (or es a consequence of): CORONARY ARTERY DISEASE Physician/Medical Due to (or as e consequence of) attending for use as ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE ed by the a Pert II. Other afgniffcant conditions contributing to death but not resulting in the underlying ceusa givan in Part I. P.O. 23b. Did tobacco use contributs to the cause of death? signed by t 1 Yas 2 No 3 Probably 4 Unknown CORONARY ARTERY BY-PASS SURGERY à 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed peed completion of ceuse of death? pege 2 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital Attending Physician: funeral director. 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 In finpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2€ No this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how Injury occurred 28b. Time of Certification: 28c. Injury at Work? After To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte complately filled in by the fune 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accident 3 ☐ Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida 16 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature end title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number

5

State Registrar 31. Dete filed (Month, Dey, Year) OCT 1 4 1997

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

.0

EDUARDO P. LAYUG M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204 32. Registrer's Signature Julia Davidson-Randelle

D24025

10-7-97

**DHMH 16 Rev 6/95** 

BELLIE HENRY PATTITURE

WELL THE THE WINDSHIP HE SAN

TOTAL MARK ARTEST TO SERVE

ANTERSTREET PROTEST CARROLL AND THE DESCRIPTION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month LUNICE BROOKS OCTOBER 10,1997 11:06 AM /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner DEATON UNIVERSITY OF MARYLAND MEDICINE BALTIMORE

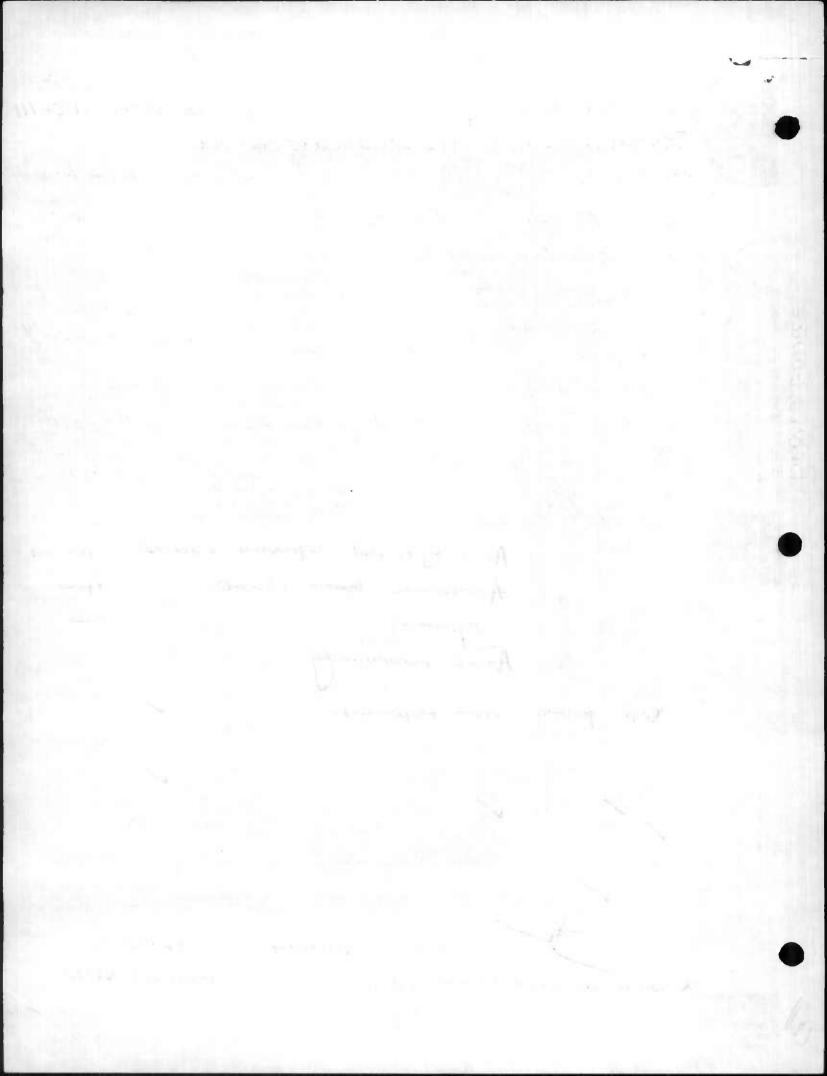
e (In yrs. last birthday)

If Under 1 Year

Months Days Hours Min. (Morgh, Day) 5. Social Sacurity Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) L. CATOL AND 7. Age (In yrs. last birthday) **Funeral** 1 M 25 F 245-26-1849 Usual Residence of Decedent 20 Director the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, it a Madical Examiner must be notified at ATLANTIC AtLANTIC 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? U517 HAMPSHIKE HUE 08401 220 NEW Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yaar or Dates: 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: by Specify: 3 Widowed 4 Divorced Black BROOKS, EUNICE 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Tropicana Hotel Elementery/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) Casino HOUSE KEEPEN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) T is mert GEOIGIA Anna J. TEAMER SI/AS DAU 15 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
705 Archic Ave ATLothe City, N. J. 19a. Informant's Name/Relationship (Type, Print) Dorothy JEWEll Department of Heelth Important: If item 27 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1≥Burial 2 □ Cremation 3 □ Removal from State Mays Landing, LINCOLD HERWIAL Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHATHAN - LINKERS F. 14. 21. Signature of Funeral Service Licensee REISTENSTOUN ROAD 5240 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medicai Immediate Cause (Final suspected Myocardial Acute 10 Minnes disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner hoonin disane. horusclowha buriel-transit pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequenca of). 104 physiclan of the buriel the portonopy Physician/Medical Due to (or as a consequenca of): 80 encephelopat naxic USB B Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause give Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vent Kep þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? peeu 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 D Natural 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending death. 1 Yes 2 No investigation 2 Accidant or Attend efter death Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10110197 11494 30. Name and eddress person who completed cause of death (Item 23a) (Type, Print) Balking wo 21230 Deaton modical contar 611 soumchantes st K' DESAI MI 31. Dete filed (Month, Day, Year)
OCT 1 4 1997 32. Registrar's Signatura State whice Davidson Randolls 1 4 1997

**DHMH 16 Rev 6/95** 

Registrar

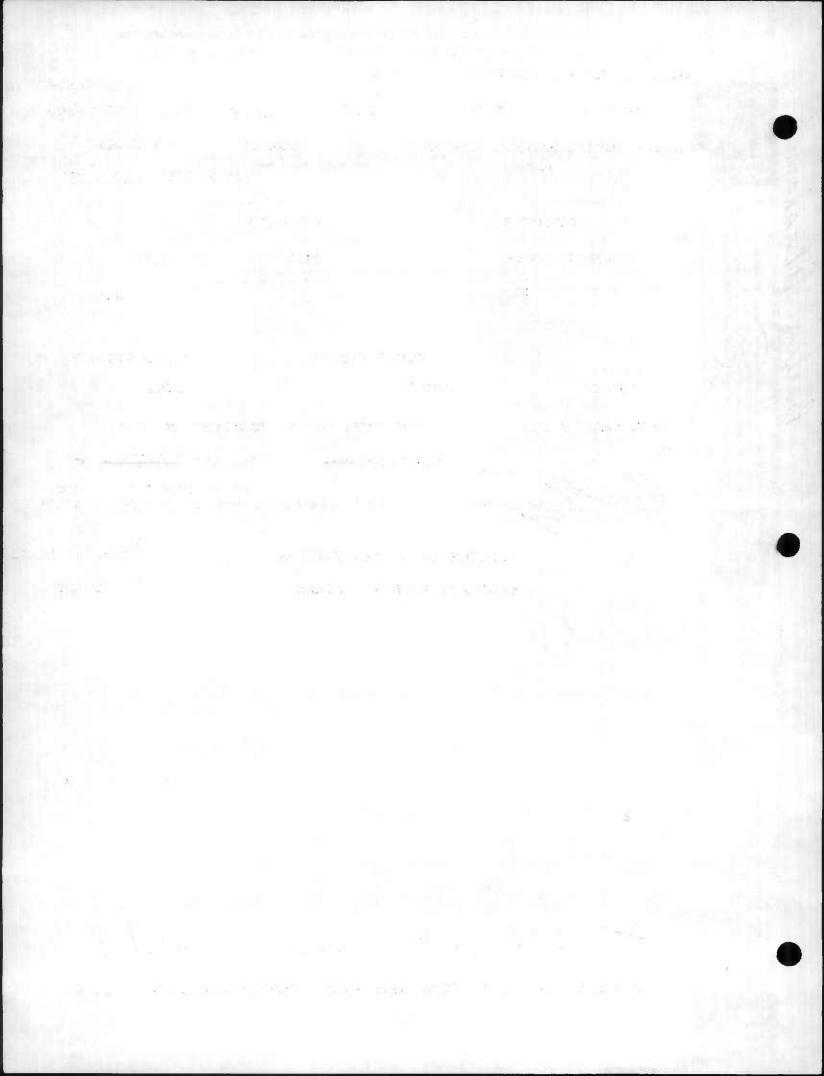


State of Maryland / Department of Health and Mental Hygiene ]

Certificate of Death ITEM#20b&20c FLM#G752 10/14/97 J.A. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yes ABRAHAM OCTOBER BERLIN 11, 1997 07:00 AM /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL CENTER TOWSON
If Under 1 Year If Under 24 Hrs. 8 BALTIMORE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** M 2□F Days Hours Min. 217-20-6395 Director Yrs. 80 MAY 2, 1917 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Items 23a 3316 SMITH AVENUE 21208 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bieck, White, etc. 1 Never Married Married NTYes 2 □ No If Yes, Give Yeer or Dates: ŏ 1 Yes 200 No Specify: WHITE à 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 21215 Elementary/Secondary (0-12) College (1-4or 5+) CLAIMS EXAMINER SOCIAL SECURITY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) SLOT PHILLIP BERLIN RICKLA 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 ETHEL BERLIN / WIFE 3316 SMITH AVENUE BALTIMORE, MD 21208 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete Pages 8 XX Burial 2 Cremetion 3 Removal from State ROSEDALE mportant 4 ☐ Donation 5 ☐ Other (Specify) 10/13/97 BALTIMORE, MD FORBAND ROSEDALE 21. Signature of Funeral Service Lice 22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximate Interval Between **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) SEVERAL WEEKS MULTIORGAN SYSTEM FAILURE Examiner Due to (or as a consequence of): Examiner **YEARS** CORONARY ARTERY DISEASE The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last and Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical Due to (or es a consequenca of): 98 for use as Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I, P.0. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2X No 3 Probably 4 Unknown signed I Records, þ should should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed has certificate 1 Yes 2 No 1 ☐ Yes No Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☑ No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Aftar 5 Pending Investigation 1 Yes 2 No Director: / 2 Accident 6 Could not be datermined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(a) and mannar as steted.

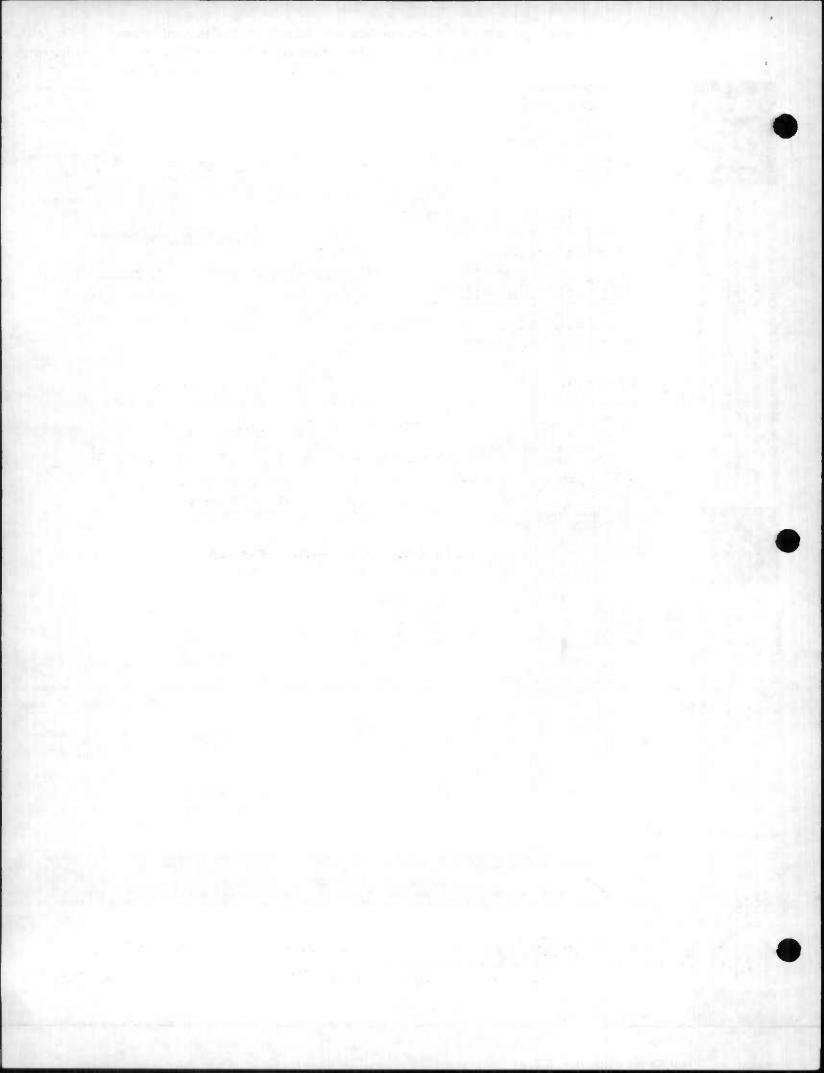
Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature end title of certification 29c. License number 29d. Date/signed (Month, Day, Year) D24034 0 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) TIMOTHY LOW, M.D. 7620 YORK ROAD TOWSON MARYLAND 21204 31. Date filed (Month, Dey, Year) 2 Registrar's Signature State whit Davidson Randell OCT Registrar 4 1997

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Deta of Deeth **Physician** Month Lawrence David Boyd 11, 1:35 AM OCT 1997 /Medical 4a. Facility Nama (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1910 Galetown Drive Severn Anne Arundel If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Sacurity Number If Under 1 Yeer Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1₽M 2□F Months Days 156-36-2530 Yrs. Director 51 AUG 7, 1946 New Jersey Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "naturel", or items 23s or 28s-f show other treumstic event, the Medical Exampler must be notified at 28a-f show MD Anne Arundel Severn 1 ☐ Yes 2 ☒ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1910 Galetown Drive 21144 USA death Funeral 12. Wes Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Dates 1969—94 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Biack, Whita, etc. filed within 72 hours after Hygiene. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes ※☐ No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "na any Injury or other treumatic event, the Medis once. Elementery/Secondery (0-12) Çollege (1-4or 5+) Lt. Colonel US Army 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Glenn D. Boyd Elouise Wright 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Patricia Y.C. Boyd/wife 1910 Galetown Dr. Severn, MD 21144, pale 20c. Location - City or Town, Stele 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 1 ☐ Buriel 2 K Cremetion 3 ☐ Removel from State Metro Crematory, Inc. 10/13/97 4 ☐ Donetlon 5 ☐ Other (Specify) Baltimore, MD Cremation Society of Maryland, Inc. 21. Signature Ferei Service Vicense reguluh Edward A. Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest shock, or haert feilure. List only one cause on each line. Approximate Intarval Between Onset and Deeth **Physician** /Medical Immedieta Ceuse (Finei 10 monihi diseese or condition resuiting in deeth) Examiner Sequentially list conditions, if eny, laading to immediata ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted avents resulting in deeth) Lest and Due to (or es e consequence of): Records, P.O. Box 68760. physician Physician/Medical 2 Dua to (or es e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the causa of death? signed by 1 Yes 2 No 3 Probably 4 Unknown þ 2 24b. Were eutopsy tindings available prior to Completed 24e. Wes an autopsy performed? completion of causa of deeth? page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes cese referred to medicei axeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Assidance 8 Other (Specify) 2 1 Yes 2 No 事 27. Menner of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of a Mospital or Attanding Pt 24 hours after death. e Funeral Director: Alter tr 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) E 4 Homicide o the hour of the form of the form of the functed Discounty Illed in Medical 29e. Certifier 1 Certifying Phyaician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29b. Signeture end titla of certifie 29c. Licansa number 29d. Date signed (Month, Day, Yeer) 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) 4940 EATTERN AVE BALTIMORG Md 21224 VATRI JYBUML MICHARL 31. Dete filed (Month, Dey, Yeer)
OCT 1 4, 190 Pegistrar's Signeture State 1 4 199 Registrar



who completed cause of death (Item 23a) (Type, Print)

Rogintar's Shouland

Locke

State Registrar 29b. Significand title of certifier

31. Date filed (Month, Day, Year)

4 199

NO

**DHMH 16 Rev 6/95** 

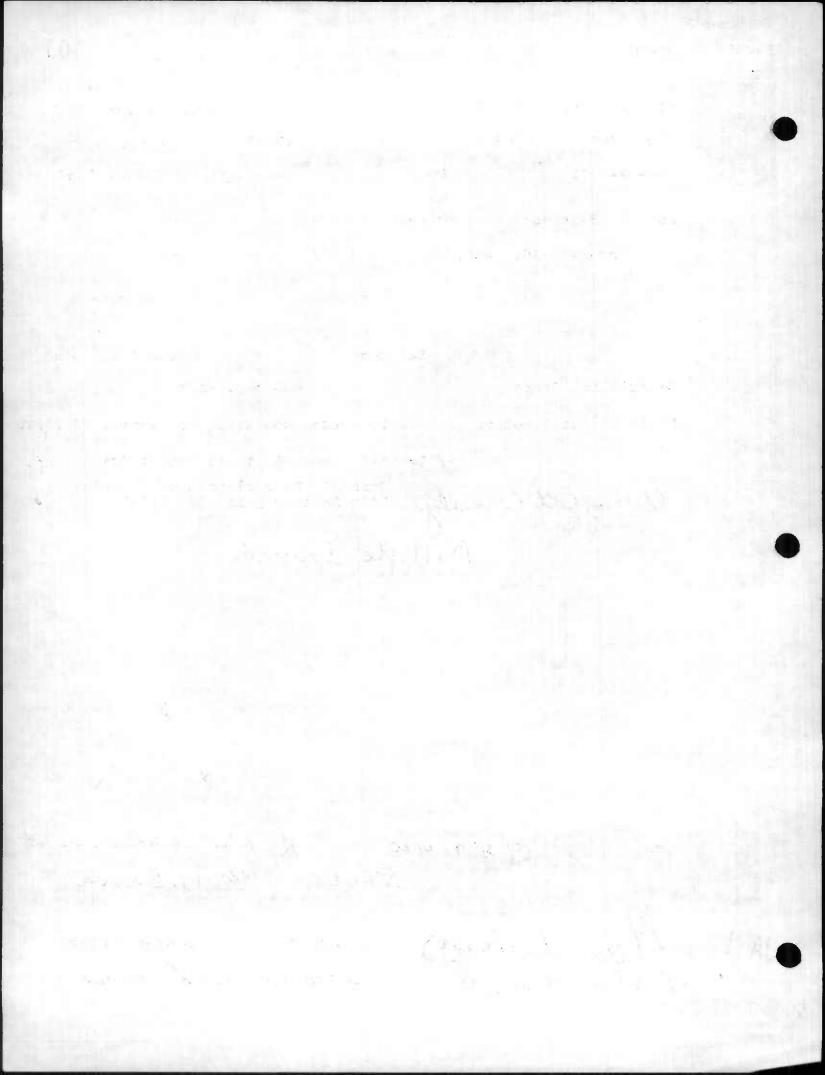
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29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

OCTOBER

13, 1997



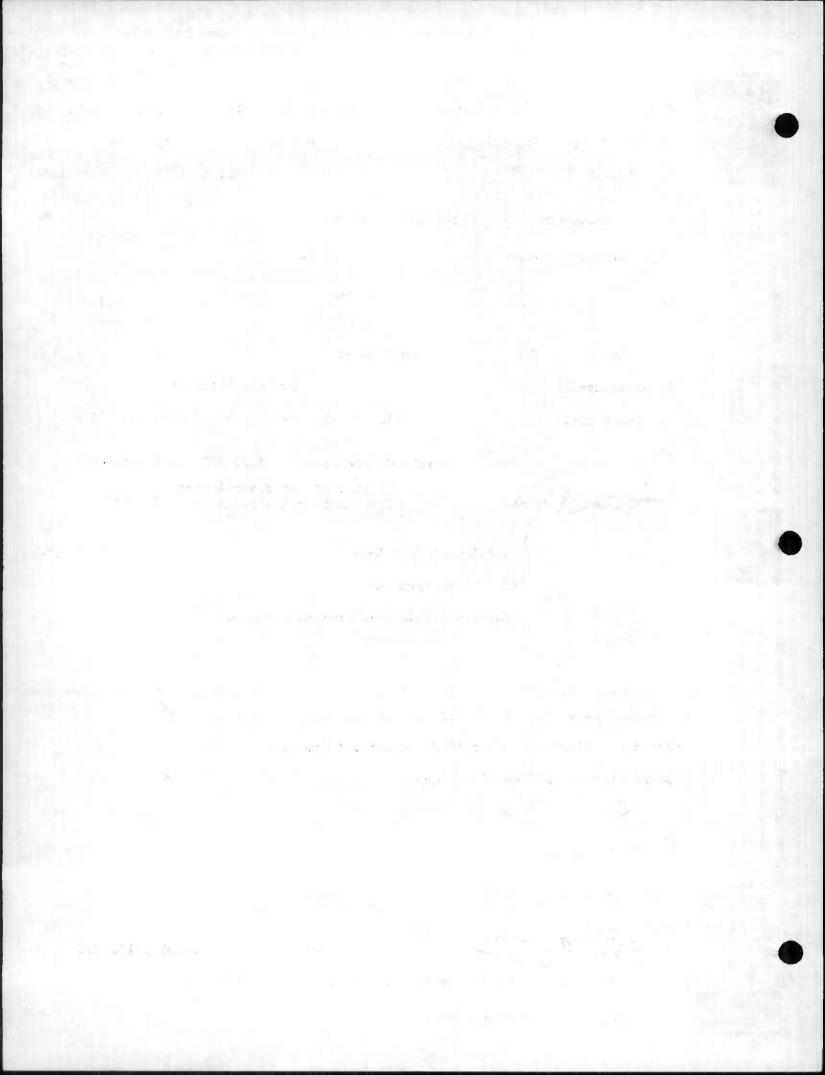
bepartment of Health and Mental Hygiene.  Examined of the strain of the	5. Sociel Security Number 217-78-6482  Usuel Residence of Decedent 10e. State 10b. Cour MD  10e. Street end Number 242 South Cor 11. Marital Status 12 Never Married 2 M 3 Widowed 4 Divorce 15. Deced (Specify only high Elementery/Secondery (0-12 12th 17. Fether's Neme (First, Middle Harry Brehm 19e. Informent's Neme/Reletic Clara Brehm 20e. Method of Disposition 1 12 University Signetic 2 Crematio 4 Donetion 5 Other 21. Signeture of Funerel Service	es Brehm  Ition, give street end numb  CONKLING STRE  6. Sex 1 X M 2 F  12. Wes Decede Armed Force 1 Yes 2; 1 Yes, Give Yeer or Date  Ident's Education whest grede completed)  College (1-4)  Iden, Last)  In the contract of	Age (In yrs. 37  10c. Ci  tent Ever in Uses? No  ss: or 5+)  ther  20b. 8	19b. Malling 242 S Plece of Disposicementary, cremate 19c. Cell	and the state of t	BALTIM  If Under 24 H Hours M  224  Hispenic Origin? John, Mexican, Pur Specify:  petion during most of w d)  tend Number or ling St.  ace)	irs. 8. Dete of Bir in. 12—13— 12—13—	10g. Citizen of W USA  14. Race Blee Specify  16b. Kind of Bu Am Vets  Meiden Sumam  er, City or Town, Dre, MAry 20c. Location - Baltima  Zanning	9. Birthplece (S County) 9. Birthplece (S Baltimo) 10d. insi 10d.	de City Limit  Yes 2 N  en  224  te  neral
bepartment of Health and Mental Hygiene.  Important: If item 27 is marked other than 'natural, or items 23s or 28s-f show any injury or other traumetic event, the Medical Examines train the or of the property of the contract of the contra	242 SOUTH CO.  5. Sociel Security Number 217-78-6482  Usuel Residence of Decedent 10e. State MD  10e. Street end Number 242 South Con.  11. Marital Status  OK Never Married 2 M 3 Widowed 4 Divorce  15. Decede (Specify only high Elementery/Secondery (0-12 12th  17. Fether's Neme (First, Middle Harry Brehm  19e. Informent's Neme/Reletic Clara Brehm  20e. Method of Disposition 1 Okburiel 2 Crematio 4 Donetion 5 Other  21. Signeture of Funerel Service  23a. Part 1. Einer the disease, shock, or heert failure. Li	onkling Stree  6. Sex  1 X M 2 F  7.  1 X M 2 F  7.  1 X M 2 F  7.  1 X M 2 F  7.  1 X M 2 F  7.  1 X M 2 F  7.  1 X M 2 F  7.  1 X M 2 F  7.  1 X M 2 F  7.  1 X M 2 F  7.  1 X M 2 F  7.  1 X M 2 F  1 Yes, Give Yeer or Date dent's Education with the st grede completed)  2 College (1-4)  2 College (1-4)  2 College (1-4)  2 College (1-4)  2 College (1-4)  3 Removal from Start (Specify)  3 College (1-4)  3 Removal from Start (Specify)  6 College (1-4)	Age (In yrs. 37  10c. Ci  tent Ever in Uses? No  ss: or 5+)  ther  20b. 8	Yrs.  ity, Town or Local Baltimo  J.S. 13. W  16e. Decede (Give k. life. Di  Wareho  19b. Malling  242 S  Plece of Disposicemetery, cremetal awn Ce  22.  26	Months Days  ation  Te  10f. Zip Code  212  es Decedent of Iffer, specify Cub  Yes 2 No  Int's Usuel Occuping of work done  DUSE WOR  Address (Street  Conkl  Lion (Name of litry) or other pile  metery  Name end Addre  3 S. Co	BALTIM  If Under 24 H Hours M  224  Hispenic Origin? John, Mexican, Pur Specify:  petion during most of w d)  tend Number or ling St.  ace)	or Location of Death IORE  Irs. 8. Dete of Bir In. 12-13-  (Specify Yes or No erto Rican, etc.)  vorking  lame (First, Middle, a Trotta  Rural Route Numb. Baltimo Dete 10/16/97	10g. Cifizen of W USA  14. Race Blee Specify  16b. Kind of Bu Am Vets Meiden Sumam er, City or Town, Ore, MARY 20c. Location Baltima Zanning	9. Birthplece (S County)  Baltimol  10d. insi 12d  Whet Country?  e - American Indick, White, etc.  Whit  usiness/industry  S  see)  Stete, Zip Code)  yland 21  City or Town, Ste  ore, MD  O Jr. Fu	tete or Fore, Ce, MD  de City Limi (Yes 2 1) N  e  224
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Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department if item 27 is marked other than "natural", or items 23a or 28a-f show and one of the marked other traumatic event, in the contract items to any injury or other traumatic event, in the contract items to any injury or other traumatic event, in the contract	10e. State MD  10e. Street end Number  242 South Con.  11. Marital Status  XX Never Married 2 M  3 Widowed 4 Divorce  15. Deced (Specify only hig.  Elementery/Secondery (0-12  12th  17. Fether's Neme (First, Midd.  Harry Brehm  19e. Informent's Neme/Reletic  Clara Brehm  20e. Method of Disposition  1 XBuriel 2 Crematio 4 Donetion 5 Other  21. Signeture of Funerel Servic  Markes  23a. Part 1. Einer the disease, shock, or heert failure. Li	nty n/a  nkling Stree  12. Wes Decede Armed Force 1   Yes   2   14 Yes   2   15 Yes   6   16   College (1-4)  17   College (1-4)  18   College (1-4)  19   College (1-4)  19   College (1-4)  19   College (1-4)  19   College (1-4)  19   College (1-4)  19   College (1-4)  19   College (1-4)  19   College (1-4)  10   College (1-4)  11   College (1-4)  12   College (1-4)  13   College (1-4)  14   College (1-4)  15   College (1-4)  16   College (1-4)  17   College (1-4)  18   College (1-4)  19   College (1-4)  19   College (1-4)  10   College (1-4)  11   College (1-4)  12   College (1-4)  13   College (1-4)  14   College (1-4)  15   College (1-4)  16   College (1-4)  17   College (1-4)  18   College (1-4)	t ent Ever in Ues? No es? or 5+)  ther  20b. 8	J.S. 13. Wiff 11 16e. Decede (Give kife. Do Wareho	and the state of t	Hispenic Origin?  Specify:  petion during most of widding most of widding to the control of the	working lame (First, Middle, a Trotta Rural Route Numb, Baltimo Dete 10/16/97	USA  14. Race Blee Specify  16b. Kind of Bu  Am Vets Meiden Sumam  er, City or Town, Ore, MARY 20c. Location Baltima  Zanning	whet Country?  e - American Indick, White, etc.  white  sales/Industry  Stete, Zip Code)  yland 21  City or Town, Ste  ore, MD  o Jr. Fu	ee 224
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Medical aminer	23a. Part 1. Enter the disease, shock, or heert failure. L								ar J raira	
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has been signed 2 should be d							24e. Wes	Yee 2 □ No en eutopsy med?  Yes 2 □ No	24b. Were euto eveileble p completion of deeth?	orior to n of ceuse
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n 24 hours of he Funeral I pletely filled edical Ce	29a. Certifier 1 Certify (Check only one) Medica	ying Physician: To the be al Examinar: On the besis end manner	st of my kno s of examine	wledge, death of tion end/or inve	ccurred et the ti stigetion, in my d	me, dete end pie opinion, deeth oc	ce, end due to the	ceuse(s) end ma	nner as steted. end due to the ce	Jse(s)
	29b. Signature end title of certification of certification of the second	1 A V	lac	19, M	D	se number			12, 199	

State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month Mary Frances BRAILSFORD 12, 1997 October 7:52 P.M. /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Franklin Square Hospital Center Rosedale Baltimore if Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 8. Date of Birth (Month, Dey, June 24 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Houra Yrs Director 1919 So. Carolina 250-01-3963 78 Usual Residence of Decadent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ehow 1 ☐ Yes 2 No Director Baltimore Baltimore Co. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21222 USA 6504 Baltimore Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours aftar cannot of Haalih and Mental Hygiena.
Int: If item 27 Is marked other than "natural", or iter
Inty or other traumatic event, the Medical Expression.
Inty or other traumatic event, the Medical Expression. Black, While, etc. I ☐ Yes 2 █ No If Yes, Give Year or Dales: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home Maker Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John Passarello Pauline Monseratt 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mayview Avenue, Baltimore, Md. 21206 William H Brailsford 20b. Piece of Disposition (Neme of carnetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State Depertment of Important: If eny injury or 4 Donetion 5 Other (Specify) 10/16/97 Moreland Memorial Baltimore Co. 21. Signeture of Funeral Servica Licensee 22. Neme and Address of Facility Hartley Miller Funeral Home 20, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7527 Harford Rd. Baltimore, Md. 21234 Approximate interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final Ventricular Arrythmia 30 Minutes disease or condition resulting in death) **Examiner** Due to (or as e consequence of) Examiner Sick Sinus Syndrome The law requires that the daath certificate be axecuted burial-transi Sequentially list conditions, if any, leading to Immediale cause. Enter Underlying Cause (Diseese or Injury Ihal initiated events resulting in death) Last and Due to (or es a consequence of): Atherosclerotic Cardiovascular Disease physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 98 USB for P.O. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. been signed by the s should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease, Status Post Myocardial Records, ð 24e. Wes an eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? Be Completed Infarction, Cirrhosis, Chronic Obstructive Pulmonary page 2 2 NNo certificate Disease, Peripheral Vascular Disease Division of Vital or Attending Physician: director, 25. Was case referred to medical 28. Plece of Deeth (Check only one) 1 Yes 28 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 12 inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 2 ☐ Accident 5 Pending eftar death. 1 Yes 2 No investigetion the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Placa of Injury - Al home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 24 hours e Hospital 29a. Certifier 🖭 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner as steted. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and the of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) RD 1922 October 12, 1997 ss of person who economicted cause of deeth (Item 23a) (Type, Print) Dr. J.S. Rana 9000 Franklin Square Drive Baltimore Maryland 21237 31. Dete filed (Month, Day, Year) 32. Registrer's Signature

Registrar

State

relia Davidson



97-5796-510 jhm DANA DONNELL CLARK

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland, / De

Days

Yaar

Department of Health and Me	ental Hygiene
Certificate of Death	Reg. No.

BALT IMORE

**Physician** /Medical **Examiner** 

1. Decedent's Nama (First, Middle, Last) 4a. Facility Nama (If not institution, give street and number)

Sex. 1X M 2□ F

2. Deta of Death

3. Time of Daath

09 , 1997 4c. County of Deeth OCTOBER 09 4b. City, Town, or Location of Death

21:54 PM

eca (State or Foraign

10d. inside City Limits

190

1 Yas 2 No

**Funeral** Director

show must be notified at 28a-f ŏ items 23a

"natural", or item filed within 72 hours after I Hygiene. other than "natura ent, tre Medical I 7 is marked other traumatic event, III Health and Mental Department of Health and Important: If item 27 is many injury or other traum

21215-0020

Baltimore, Maryland

68760

Box

P.0.

Records,

Division of Vital

**Physiclan** /Medical Examiner

Physician/Medical Examiner the signed b by Be Completed Certification: To or Attending after death Director: 3

SHOCK TRAUMA UNIT 5. Social Security Number 219-92-9887 219 Usual Rasidence of Dacedant 10a. State 10b. County Completed by Funeral Director lary and 10e. Straet and Number 56 1 Navar Married 2 Married 3 ☐ Widowed 4 ☐ Divorced Elementary/Secondery (0-12) 10 17. Fathar's Nama (First, Middla, Last) Be Iliam Bernice 20a. Mathod of Disposition 1 Burial 2 Crametion 3 Ramoval from Stata 4 Donetion 5 NOther (Spacify) Entombment Holly Immediata Cause (Final disaasa or condition resulting in daath)

if Undar 1 Year 7. Aga (In yrs. last birthday) Yrs.

Town or Location more 10f. Zip Coda

2 d 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yas 2 No Specify:

 Race - Amarican Indian Black, White, atc. Specify:

15. Decedent's Education (Spacify only highest grada complated) College (1-4or 5+)

ar

12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☑ Yas 2 □ No If Yes, Giva Year or Datas:

16e. Decedant's Usual Occupation (Giva kind of work done during most of working life\_DO NOT usa retired)

18. Mother's Nama (First, Middla, Maidan Surnama) Son

16b. Kind of Business/Indust

10g. Citizan of What Country

19a Informant's Nama/Raiationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Ro Son 20b. Place of Disposition camatery, cramatory

ute Number, City or To Date Mem. Gardens

21. Signatura of Funaral Service Licansan Entar tha disasse, or complications that caused tha death. Do not antar the mode of dying, such as cardiec or respiratory arrest, or heart failure. List only one cause on each line.

22. Name end, Address of Facility
Joseph L. Huss
222 W. North ゴネス

tue Approximate Interval Betw

MULTIPLE GUN HOT WOUMS

Sequentielly list conditions, if eny, laading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

1 Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

Dua to (or as a consequence of): Dua to (or es a consequance of):

21158

28e. Pleca of Injury - At homa, farm, street, fectory, office building, atc. (Specify)

Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown

24a. Was an autopsy performed?

1-Yas

26. Placa of Death (Check only ona)

24b. Wara autopsy findings available prior to complation of cause of death?

1 Yas 2 No

Onsat and Death

25. Wes casa referred to medical axaminer? 1 ☐ Yas 2 ☐ No 27. Manner of Death

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Data of Injury (Month, Day Year) 28b. Time of Injury 10 997

28c. Injury at Work? 1 Yas

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 26d. Describe how Injury occurred

> SUMSJOUTS HOT 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

STREET (Check only

2200 was they are is out no its 1 Cartifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signetura and titla of cartifiar

5 Panding invastigation

6 ☐ Could not be determined

29c. License number OCME

29d. Data signed (Month, Day, Year) OCTOBER 10, 1997

30. Nema and address of person who completed causa of death (Itam 23a) (Typa, Print)

MANY SUTS
31. Data tiled (Month, Day, Year)

OCT 14 1997

KONOW LW. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medicai

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 7 3 0 8 1

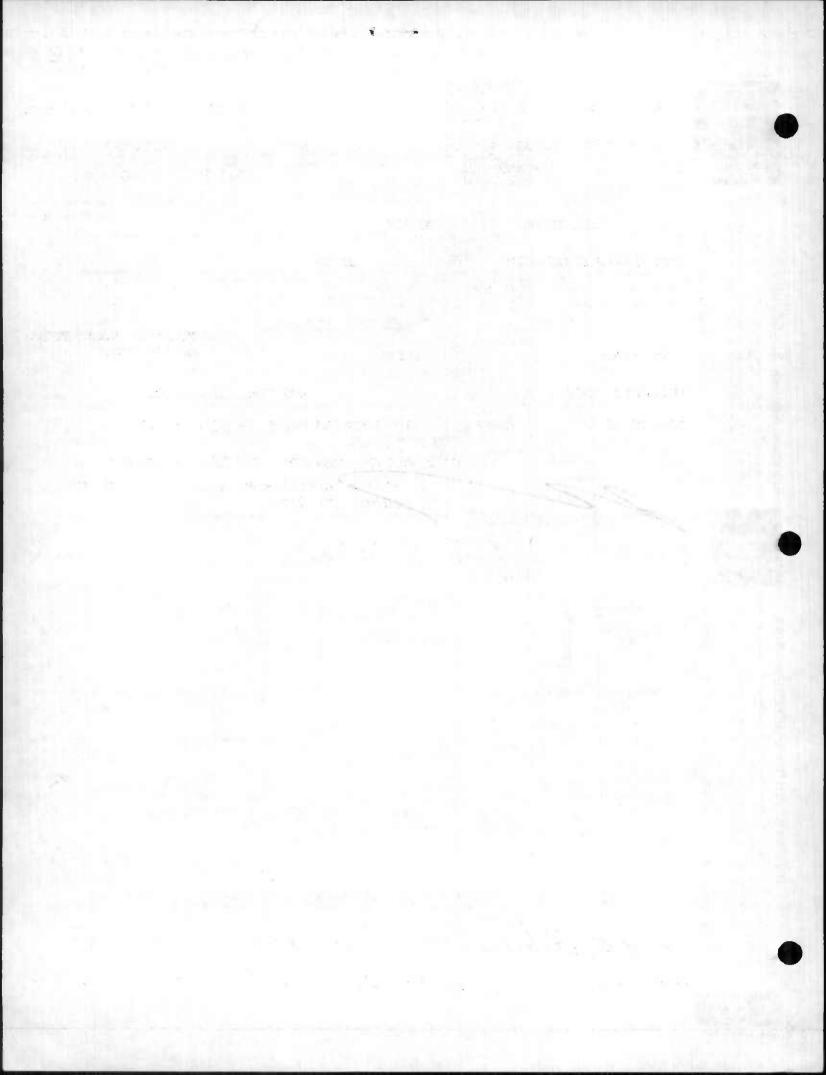
					Certifica	ate of	Death	P	leg. No.		
Obvojsi		1. Decedent's Nama (First, Middle, Last					1000	2. Data of Dea Month		Year	3. Time of Death
Physicia /Medic		JOSEPHINE	COF	POC	-A			OCTOBE		1997	450AN
Examin		4a. Facility Name (If nodinstitution, giva  LOCIEN FRANK	streat and number)	Vure		MER	BA	Location of Death	N/A	y of Death	
Funeral Director		5. Social Security Number 6. Sa 220-14-6550 Usual Residence of Decedent	7. Age	(In yrs. la:	Month	der 1 Year 18 Deys	If Undar 24 Hrs Hours Min		2, 1910	Coun	iaca (Stata or Fora try) / Land
show		10a. State 10b. County		10c. City,	Town or Location					1	0d. Inside City Lim
28a-f shor	ctor	Maryland N/A		1	Baltimore						1 XYes 2 □
	Directo	10e. Street and Number			10f.	Zip Coda		1	0g. Citizen of	What Cour	try?
		4211 Parkwood Aven				1206				ed Sta	
0 2	by Funeral	11. Maritai Status  1 □ Navar Married 2 □ Married  3 ☒ Widowad 4 □ Divorced	12. Was Decedent E Armed Forcas? 1 Yes 2 XN If Yes, Giva Yaar or Dates:		If Yes, s	cedent of F pecify Cub 2 X No	dispanic Orlgin? (S an, Mexican, Puer Specify:	Specify Yas or No- to Rican, atc.)		ce - Americ ck, Whita, by: Whi	etc.
"natural",	ted	15. Decadent's Edu	ucation		16a. Decedent's U	sual Occup	pation	dia	16b. Kind of B	usiness/ind	Justry
. 5	Completed	(Specify only highast grad Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT	use retire	during most of wo d)	rking			
ygier it, the	Co	8			Homemake	r			Own Ho		
nd Mental Hygie merked other ti umatic event, th	Be	17. Fathar's Name (First, Middla, Last)						me (First, Middle,	Maiden Sumar	na)	
narke natic	2	Pasquale Vito	8.1.1					ta Russo			
7 is m traum		19a. Informant's Name/Relationship (T)						ural Route Number			
of Health end Mental Hygiens If Itam 27 is merked other tha or other traumatic event, the		Ernest P. Coppola  20a. Method of Disposition	/ Son	20b. Pla	ce of Disposition (A	vame of	d Avenue	Baltim	ore, MI		
y or of		1 ☐ Burial 2 【X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			netery, crematory o	40 /44 /07					
any and conc	21. Signature of Funeral Service Licens		HIII	top Serv		orp.	10/11/97	Iowsor	i, Mar	yland	
	> milton }	Enright		Leona 5305	rd J. Harfo	Ruck, I ord Road	nc. Fune Baltimo	re, MD	ne 21214		
ysician Medicai fr		23a. Part1. Enter the disease, & Compi shock, or heart failure. List only of	ne cause of each line	9.		-					Approximete Interval Between Onset and Death
		fmmediate Cause (Final	Atho	00/	relevot.	-/	de il	0-	Nicm.	10	CATA OF
		disease or condition resulting in death)	a				anovaso	mean 1	Jisem	HC .	YEAR!
	Jer			Due to (or a	is a consequenca o	of):					/
ansit	Examiner	Sequentially list conditions,	b. ———	ue to (or a	s a consequence	f)·					
an er		if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			0 0011004001100	.,,.					
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ed by the ettendir deteched for use	Physician	Part II. Other significant conditions cor	ntributing to death but	not resulti	ng in the underlying	g cause giv	ven in Part I.	23b. Did to	bacco ues co	ptributs to	the cause of dea
detec		Dementi	<u> </u>					1□Y	2 DANO	3 Prot	ably 4 Unkn
gg .	d by							24a. Was a	n eutoneu	24h We	ra autopsy finding
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page 2	dm								_/		death?
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	o Be	25. Was casa referred to medical axaminer?	dospital:			Oth	ner .	ath (Check only on			
	<b>-</b>	27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury (Month, Day		NOutpatient 3	DUA	4 Nursing I	łome 5 ☐ Reside			")
or: After the	tlor	1 Pending 2 Accident S Pending Investigation	(Month, Day	Year)	Injury M	28c. Injur Wor	rk? Yes 2□No				
To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injur building, etc.	y - At hom (Specify)	e, ferm, street, fact	ory, office		28f. Location (St City or Town	reet and Numl n, State)	per or Rura	Route Number,
Funera letely fills	edicai	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	nician: To the best of ner: On the basis of e	xamination	edge, death occurre and/or investigetion	ed et the tir	me, dete and plece pinion, death occu	e, end due to the curred at the time, d	ause(s) end ma ate and place,	anner as st and due to	eted. the cause(s)
omp omp	-	29b. Signature and title of gertifiar	1/-1		. 1 2	9c. Licens	e number	2	9d. Data signe	d (Month, I	Day, Year)
		* Fredrich	Mus	1	10)	12	2645		10/10	197	
		2 Moone				DC	41 7		10/10	///	
1/		<ol><li>Name and address of person who loo</li></ol>	Indicated cause of de-	ath (Item ')	3a) (Type Print)				/ /		
1		30. Name and address of person who be	RKGS A	1 i )	3a) (Type, Print)	CARI	ED AVE.	BALTO.	ms. E	2122	2

55 Refer to bell to 13.313 Streta Month 1 ... . MACHE IN THE FIRST COUNTY OF THE PARTY OF TH Internet some sit said office before the contract of 

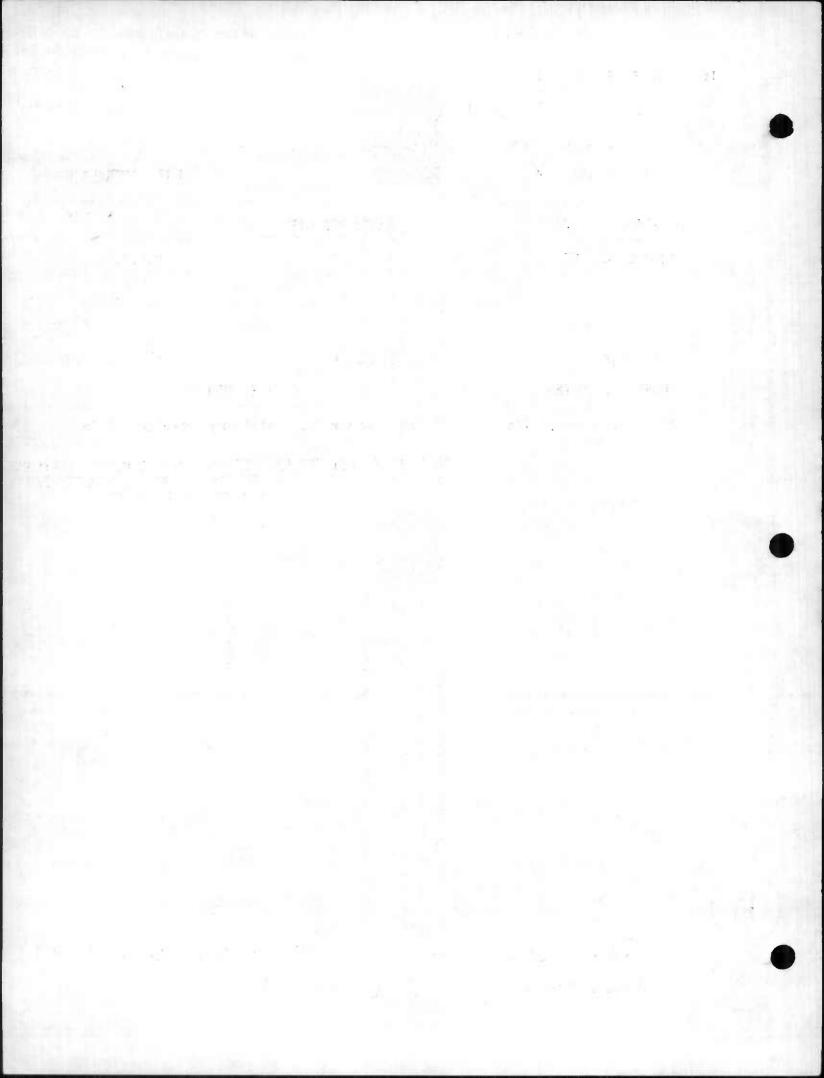
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Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Physician Month Yaar MARIE ROSE CAMPO **OCTOBER** 8 1997 9:25 P.M. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b City Town or Location of Death 4c. County of Death Examiner MANOR CARE - RUXTON TOWSON if Undar 24 Hrs. BALTIMORE If Undar 1 Year Birthpiaca (Stata or Foraign Country) 5. Social Sacurity Number 6 Sax 7. Aga (In yrs. last birthday) **Funeral** Days Hours 10 M 20 F 095-03-4663 Yrs. Director 87 9/1/10 NEW YORK Usual Rasidance of Decedant the Marylend 10a Stata 10b. County 10c. Clty, Town or Location 10d. fnsida City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yas 2X No MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8 Items 23a Apt. H Funeral USA 14. Race - Amarican Indian, Blsck, Whita, atc. 6865 OUEENS FERRY ROAD 21239 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours effer of Deperment of Heelth and Mental hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Expriser once. 1 Yas 20 No If Yas, Giva Yaar or Datas: M Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry MD STATE DEPARTMENT Elamantary/Secondary (0-12) Coilega (1-4or 5+) OF EDUCATION 12th GRADE CLERK 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be GIOVANNI CAMPO ANGELINA DIDOMENICO 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) JOHN CAMPO NEPHEW 1706 WOODHOLM DRIVE BELAIR, MD 21015 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Other (Specify) MOST HOLY REDEEMER CEM. 10/11/97 BALTIMORE, MD 21. Signature of Funaral Sarvice Licensas 22. Nama and Andrass of Facility
JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. POWSON, MD 21286 23a. Park. Entar tha disaasa, or compilications that caused the death. Bo not antar the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. **Physician** /Medical tmmediata Causa (Final disaasa or condition rasulting in death) Examiner physician and the buriel-trensit that the death certificate be executed Exami Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medicai Dua to (or as a consequance of) use Part Ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, þ The law requires 24b. Wara autopsy findings availabla prior to complation of cause of daath? 24a. Was an autopsy performad? Completed page 2 1 Yas 2 No 1 ☐ Yas 2000 certificate Division of Vital or Attending Physician: director Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) axaminar? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 10 this 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Affer Naturai 2 Accidant 5 Panding 1 Yas 2 No death. invastigation ofter death Director: A d in by the f 6 Could not be datarmined 3 Sulcida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homloida To the Hospital of within 24 hours of To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edicai 29a. Certifiar (Check only one) 29b. Signatura and titla of certifiar 29c. Licanse number 29d. Data signed (Month, Day, Year) 2-12849 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) ADI, ME TERE OSLER Dr. TOWSON, Md 21204 State Registrar



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amine	r	Baltimor			\			+, more		4c. County	or Death		
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TOBO	Ď	OLIVER F. COATES						A E. CEF		our carrain	٠,		
-	-	19a. Informant's Neme/Ralationship (	Type, Print)	1	9b. Meilir	ng Addrass (Street				ity or Town,	Stata, Zip	Code)	
		Almeta J. Coates	/Wife		4008	Bonner I	Rd. Ba	altimore	. Ma	rvland	212	16	
		20e. Mathod of Disposition	n	20b. Place	of Dispo	sition (Name of natory or other pla		Deta		c. Location -			
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ician dical	21. Signature of Funarel Sarvica Luciu	BROWN	COMMI	JNITY F/	Н								
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		27. Mannar of Deeth 1 DNatural 5 ☐ Pending	28a. Data of in (Month, D	ury 26 ey Year)	b. Tima of Injury	28c. inju	ry at rk?	26d. Das	cribe how	injury occurre	ed		
Certification:	3	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 No						
		4 Homicida datamined	28a. Place of I	njury - At home itc. <i>(Specify)</i>	, farm, str	aet, factory, office		28f. Loca City	tion (Street or Town, S	it and Numbe Stata)	er or Rura	Routa Number,	
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edical			ysician: To the besi ninar: On the basis and mannar s	of axamination	and/or inv	estigation, in my o	ppinion, daath	occurred at tha	tima, data	and placa, a	ind dua to	tha causa(s)	
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	-	30. Nama and addrass of person who	completed causa of	daath (Itam 23	a) (Type, I	Print)	11 10	7011	10	COCIO	V.C.	,,,,,,	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Per No. 9 7 308 | 4

				Cei	nificate	e or i	Death		Reg. No.		0014
Physicia /Medic		1. Decedent's Name (First, Middle, Last,	1. Corbin				. O. T.	2. Dete of D Month	067/	Year 797	3. Time of Death
Examin	er	4a. Facility Name (If not Institution, give	gel Nusi	y Ho	me		Baltini	r Location of Dea	th 4c. Count		
Funeral Director		5. Social Security Number 6. Set 219 - 42 - 6247 15  Usual Residence of Decedent	7. Age (In yrs.	last birthdey) Yrs.	If Under 1 Months	1 Year Deys	If Under 24 Hr Hours Mir	(Month D	rth ay, Year) -/9/7	9. Birthp Coun	lace (State or Foreign try) Md
Maryland Fet show	tor	10a, Stete 10b. County  Md NA		ty, Town or Lo						1	0d. Inside City Limits 1 1 yes 2 □ No
with the	Direc	10e. Street end Number 808 N. Ben to	Van Store ex	L	10f. Zip (		1216		10g. Citizen of	What Coun	
is 1 and 2 should be filed within 72 hours efter deeth with the Maryland if Health end Mental Hygiene. Ifem 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at	by Funeral Director		12. Wes Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decede	ent of H		Specify Yes or N rto Rican, etc.)		ce - Americ	an Indien,
filed within 72 hours Hygiene. Ather then "natural", ent, the Medical Exa	Completed	15. Decedent's Edu (Specify only highest gred Elementery/Secondery (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	k done d	during most of w	orking Fer	16b. Kind of E	Susiness/inc	ecurity
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1 and 2 sho Health end N em 27 le ma ther traume		19a. Informant's Name/Reletionship (Ty Brian Corbin	-Son	343	39 6	SIM	and Number or F	Aural Route Number Street	Bal	to, rey	21213
Page nent c ant: If ury or		20a. Method of Disposition  1 Burial 2 Cremation 3 F  Condition 5 Other (Specify)  21. Signature of Funeral Service License	emoval from State	Place of Disponentery, crer	on For	her plac	a)  + Uet ss of Facility;	Date 10-14-97	Owny	- City or To	wn, State
Departr Importu any Inje		Is ladys.	Warre	C	anh	F.#	West 4300	Wabas	h gren	rue k	Ba Ho red
Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury	).	ATC or es a consec or as a consec		SR	EAST	CAN	CER		
nding use	an/Medical	Cause (Diseese or Injury that intieted events resulting In death) Last	Due to (c	r as a conseq	juenca of):						
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Attending Ph or deeth. actor: After thi by the funeral	Certification:	27. Manner of Death  10 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Dete of Injury (Month, Dey Yeer)	28b. Time of injury	f 28	Bc. Injun Worl	/ et ⟨? Yes 2 □ No	28d. Describe	how injury occu	rred	
To the Hospital or Attent within 24 hours after deet To the Funeral Director: completely filled in by the	Certif	4 Homicide determined	City or To	(Street end Num. iwn, State)							
To the Hospital of within 24 hours af To the Funeral DI completely filled in	edicai		lcian: To the best of my knower: On the basis of examination and manner stated.								
To the within To the comp	Me	29b. Signature and title of certifier	lehani	,	29c.	License	number		29d. Date signe	ed (Month,	Day, Year)
5		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print)	RK	He	Cott	AVE	BA	UD MA
Stat	е	31. Date filed (Month, Dey, Yeer)	19. Rolliffran's Signa	handelle			110	4713	1,10	,	21208

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** Month Year Oct 12, 4:00 am Nellie E. 1997 /Medical 4b. City. Town, or Location of Death 4a. Facility Nama (If not Institution, give street and number) 4c. County of Death **Examiner** 4232 Elsa Terrace N/A Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug 21, 1 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 3 X 85 Yrs. Director 215-01-1958 1912 Maryland Usual Residence of Decedant the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examiner maint be notified at N/A Maryland Baltimore 1DXYas 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4232 Elsa Terrace 21211 U.S.A death Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education 16h Kind of Rusinass/Industry (Specify only highest grade completed) permit. Peges 1 and 2 should be filed within Dapartment of Health and Mentel Hygiene. Important: If Item 27 is marked other than eny Injury or other traumatic avant Maryland Casualty Elementary/Secondary (0-12) College (1-4or 5+) Insurance Underwritter Ins. Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Mary McGrath William F. Zurgable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4420 Macworth Place, Baltimore, Maryland 21236 Gwendolyn M. Merson (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burlat 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 10/15/97 Baltimore, Md Parkwood Cemetery 21. Signature of Funeral Sarvice Licenses 22. Name and Addrass of Facility A. Alan Seitz, Jr. Funeral Home an 3818 Roland Avenue, Baltimore, Maryland 21211 23a. Part1. Enter the disaasa, or complications that ceusad the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** SUNDEN CORDIAC DEATH. Immediate Cause (Final disease or condition rasulting In death) /Medical **Examiner** Due to (or as a consequence of):

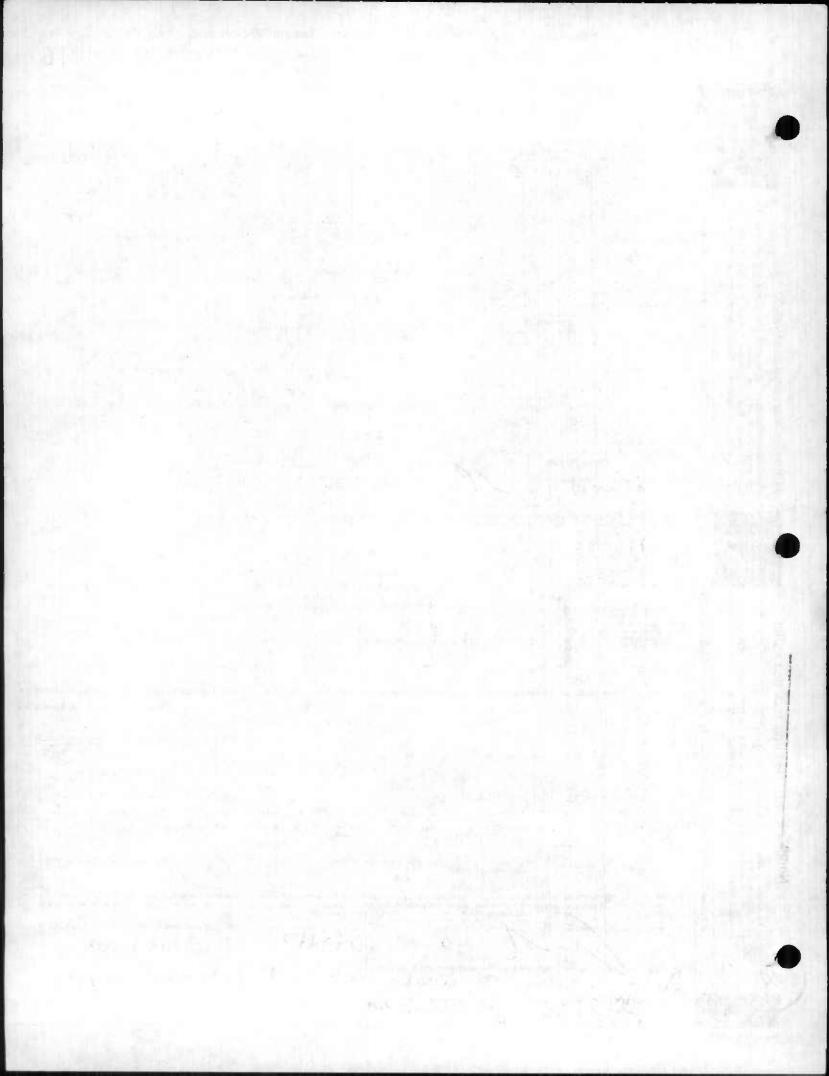
CAAI, OVA (CVA)

Due to (or as a consequence of):

11/1/CA) pue Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician sthe burial Box 68760. The law requires that the deeth certificate be Physician/Medical Dua to (or as a consequence of) attending p signed by the a P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 45AN EA11 Records, þ 24a. Was an autopsy performad? 24b. Ware autopsy findings available prior to completion of ceuse of daath? Completed peed pege 2 s certificate 2 No 1 ☐ Yes 2 No Division of Vital at or Attending Physician: The safter death.
If Director: After this certificated in by the funeral director, predictions of in by the funeral director, predictions. 25. Was cesa rafarred to medical Be 26. Placa of Daath (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 A Residence 8 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1. Natural A -1 Yes 2 No 2 Accident 6 Could not be determined 28a. Place of injury - At home, farm, straet, factory, office building, etc. (Specify) 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, Stata) 4 ☐ Homicide the Hospital or the Euneral Di The Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowladga, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. To De 29d. Date signed (Month, Day, Year) deno mD. 725/64 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) 5601 (OCH RAVEN BLV) BACT. M.J. 2123 6,6 MI). 31. Data filed (Month, Day, Year) Registrar's Signature State Registrar

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neral	7	5. Social Security Number 6.	Sex 7	Age (In yrs.	lest birthday)	If Under 1	Year if Under 24 H	rs. 8. Date of E			e (Stete or Fore	
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nothing at	6	10e. Street end Number				10f. Zip Cr			10g. Citizen of	What Country	?	
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To				161	10h Mailie	a Address /6	Straet end Number or		na Amsp		adal	
Then		19a. informant's Name/Relationship Jeff M. Rhodu:		on			et Drive		apolis, MD 21403			
or other traumatic event, the M	1	20a. Method of Disposition			Place of Disponentery, crem			Dete		20c. Location - City or Town, State		
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e de de		Edward A.	Lagart	C	C:	remat	ion Soci				01000	
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siclan		shock, or heart failure. List only	y one cause on aa		^					O	nsat and Deetl	
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Marylan

d / Department of Health and Ment	al Hygiene O	2001
Certificate of Death	Reg. No.	3081

Physician
/Medicai
Examiner

certificate be executed signed by The law Division of Vital this After or Attending death. s efter death in by To the Hospital of within 24 hours a To the Funeral Completely filled

Funeral Director 10e. Stete 28a-f show notified Director 10e. Street and Number 8 8 death with items 23a 11. Marital Status Peges 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0020 natural', or by Completed Hygiene. 뎚 Be end Mental marked : If item 27 Is no or other traur Heelth ( permit. Pages 1 Department of H Important: If its eny Injury or ot Physician Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Box 68760. Physician/Medical P.O. Records, by Completed Be Certification: To

5. Sociel Security Number 231-17-4968 Usuel Residence of Decedent 10b. County Maryland N/A 2828 Maudlin Avenue 1 Never Married 2 Married 3 ☐ Widowed 4 ☑ Divorced Elementery/Secondery (0-12) 17. Fether's Neme (First, Middle, Last) Anthony F. Cataldi 20e. Method of Disposition 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest

1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Deeth Day Daniel J. Cataldi October11,1997 1000am 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth MD HOUSE OF CORRECTION **JESSUP** ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1 M 2□ F Months Deys Hours 47 Yrs. Oct. 6, 1950 Maryland 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore 10f. Zip Code 10g. Citizen of Whet Country? 21230 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Yes 2 No Specify: White Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) 8 Bartender Bar 18. Mother's Name (First, Middle, Maiden Surname) Doris Eileen Henry 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Roberts / Sister 2828 Maudlin Avenue, Baltimore, MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Burlal 2 Cremation 3 Removel from State 10/15/97 Baltimore, MD Cedar Hill Cemetery 22. Name end Address of Fecility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, MD 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death a Hypertensive Atherosclerotic Cardiovascular Disrase Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of):

Part II. Other significent conditions of	ontributing to death but not res	sulting in the underlying caus	se given in Pert I.	23b. Did tobecco usa c	ontributa to the cause of death 3 Probably 4 TUnknow
				24a. Wes an autopsy performed?	24b. Were autopsy tindings aveilable prior to completion of cause of death?  1.△ Yes 2□ No
25. Was case referred to medical exeminer?			26. Piece of De	eeth (Check only one)	
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3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory, o	ffice	28f. Location (Street and Num City or Town, State)	nber or Rurel Route Number,
29a. Certifier (Check only one) 1 Certifying Ph	yelclan: To the best of my kno liner: On the besis of examine and menner stated.	owiedge, death occurred et t etion end/or investigetion, in	he time, dete end plac my opinion, deeth occ	se, end due to the ceuse(s) end neurred at the time, date end place	nenner es stated. e, end due to the ceuse(s)

State Registrar

Medical

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) October 12, 1997

e and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Radentz 111 Penn Street, Baltimore, Maryland 21201 5,

Stephen 32. Registrer's Signature led (Month, Day, Year) 1 4 1997

Note that the state of the stat

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month MELVIN COLE JR. October 9 1997 7:00 PM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner VA MHCS FORT HOWARD DIVISION BALTIMORE CO. 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Yrs. Director 214-62-5167 45 SEPT.13,1952 MARYLAND Usuel Residence of Decedent 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits al', or items 23e or 26e-f ehov Examiner must be notified at 1 Nes 2 No Directo MARYLAND BALTIMORE CITY 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2813 ERDMAN AVENUE 21213 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

Will Yes 2 INO JAN 03/73 I Yes 2 No Specify: Yeer or Detes: DEC 10/74 Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Married à Specify: NEGRO 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A TRUCK DRIVER PRIVATE CO. 17. Father's Neme (First, Middle, Last) 16. Mother's Neme (First, Middle, Maiden Sumame) Be MELVIN COLE, SR. MARY L. BLACKWELL 19a. Informant's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Lepartment of Health as Important: If them 27 is any injury ---VALESTINE COLE -WIFE 2813 ERDMAN AVE. BALTO, MD. 21213 OCT. 14,1997 Location - City or Town, Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 1 ☑Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete GARRISON FOREST VETERAN CEM. 4 ☐ Donetlon 5 ☐ Other (Specify) OWINGS MILLS, MARYLAND 21. Slorature of Funerel Service Ligensee 22. Name and Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME 1412 F. PRESTON ST. BALTO, MD. and death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Pert1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each limit Approximate Interval Between Onset and Deeth **Physician** Immediete Ceuse (Final diseese or condition resulting in death) /Medical . Sepsis with multiple skin abscesses 1 Month Examiner Due to (or as a consequence of): be executed physician and is the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Pneumonia, Dibetis Mellitus, Cardiomyopathy Records, 24b. Were sutopsy findings evalleble prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? Hepatitis C, Alcohol Abuse page 2 1 Yes 2 No of Vital 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: XXInpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2X No this 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After Division or Attending 1 Neturei 5 Pending Investigation s after death.

i Director: Aid in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours at To the Funeral C completely filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) and manner as stated.

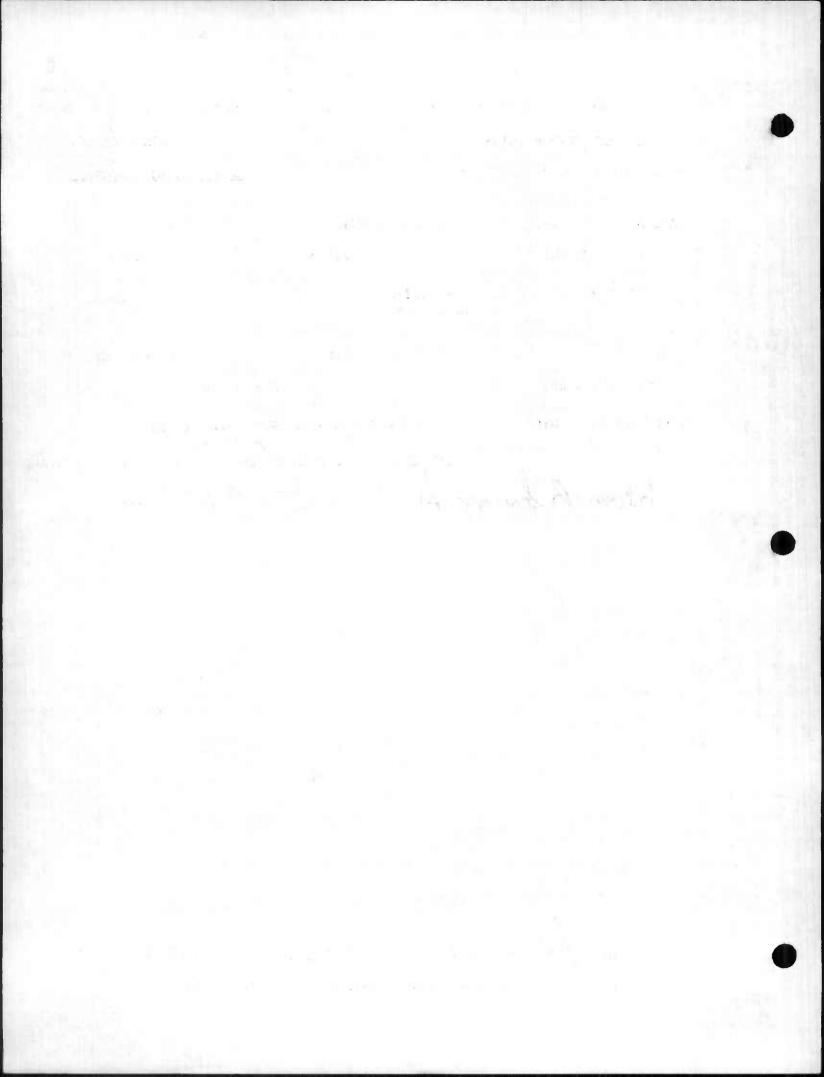
| Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and piace, and due to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) Muna 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) 9600 North Point Road, Fort Howard, MD 21052 Marcos Galicia, MD

Registrar **DHMH 16 Rev 6/95** 

State

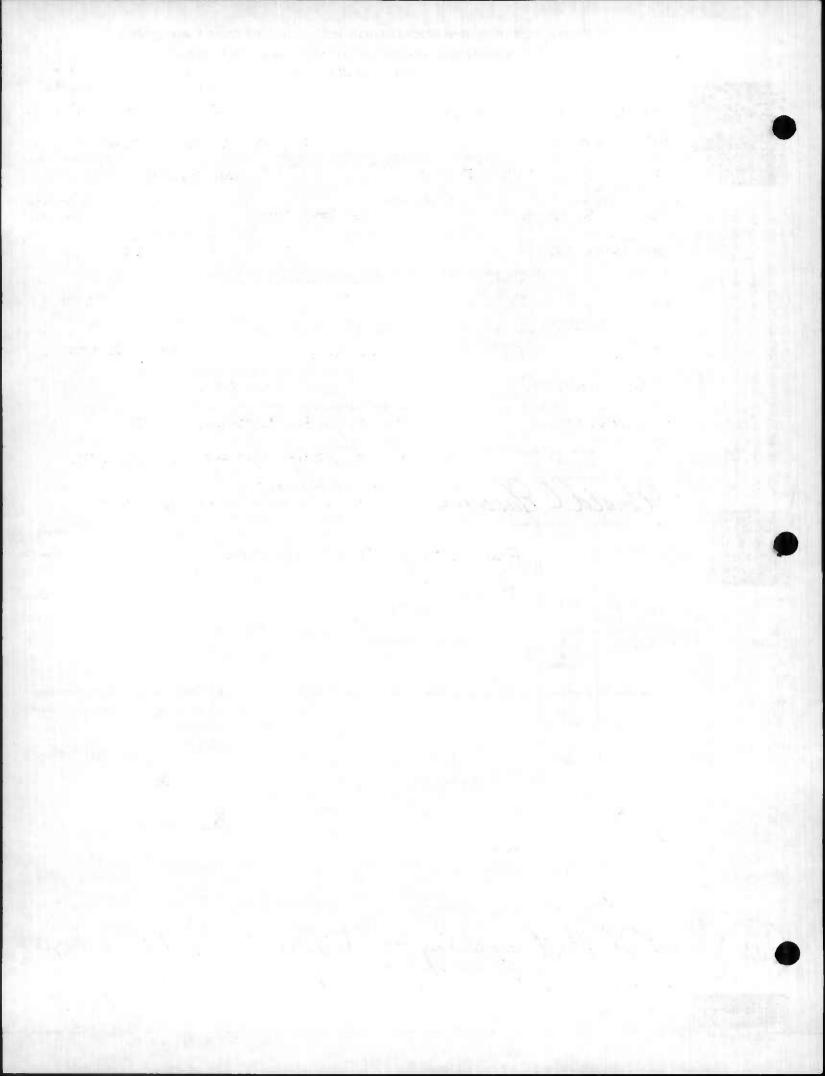
31. Date filed (Month, Day, Year)

Julia Altonomi's Signature P. 62



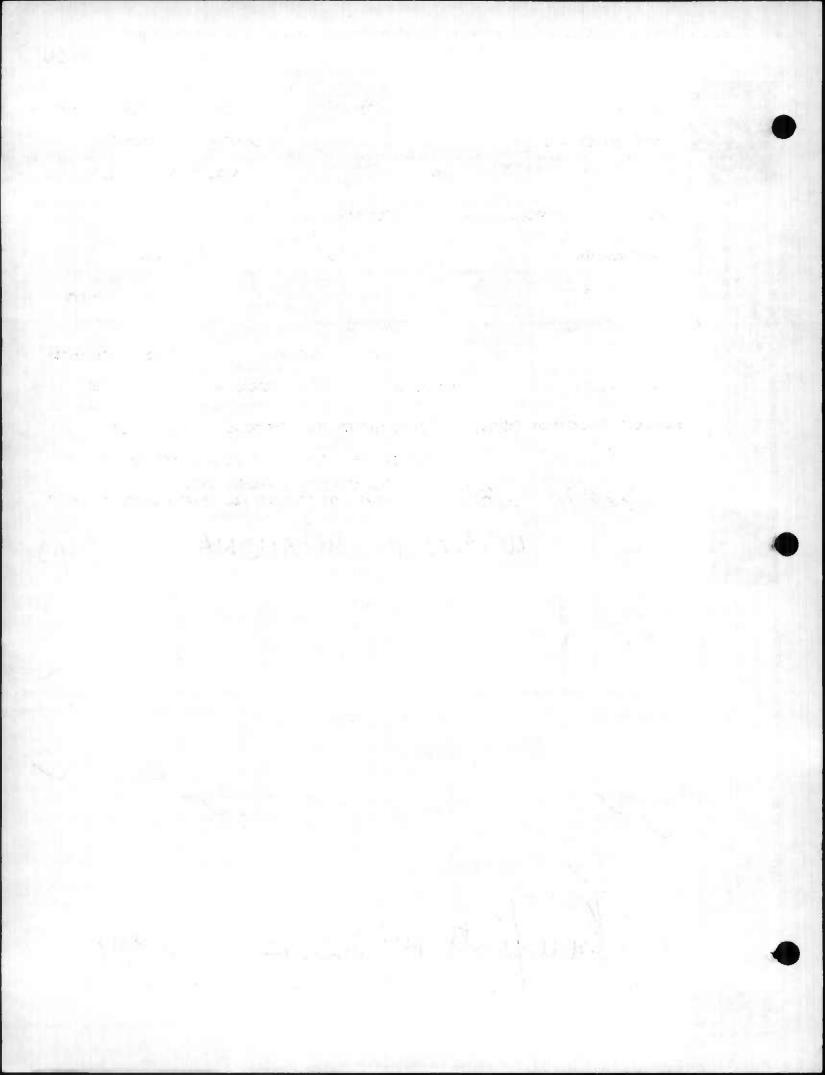
State of Maryland / Department of Health and Mental Hygiene 7 308 | 9

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ats 7	De										p3.1		C	ompletion of cause f deeth?
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State of Maryland / Department of Health and Mental Hygiene 9 7 30820

					Cei	tificate d	of Death	R	eg. No.		004	
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Examiner	-	4e. Facility Name (If not institution	, give street end number	er)			4b. City, Town, o	or Location of Deeth	4c. County	of Deeth		
	4	3450 HALTER I	D.					TMINSTER		RROLI		
uneral rector		5. Sociel Security Numbar  220-52-4471  Usuel Residance of Decedent	6. Sex 7. 1 □ M 2 □ XF	Age (In yrs. la 49	st birthday) Yrs.	If Under 1 You Months De			, Year) , 1948	9. Birthp Coun NI	elece (Stete or stry) EW YORI	r Foreign K
show id at		10e. Steta 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside Cit	ly Limits
ust be notified at	5	MD	CARROLL		WES	STMINST	ER				1 🗓 Yas	2 🗆 No
		10e. Street end Number 3450 HALTER I	w.			10f. Zip Coo		1	0g. Citizen of V USA		try?	
by	2	11. Maritel Status  1 ☐ Never Merried 2 ※ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Wes Dacadal Armed Force ed 1  Yes 2 If Yas, Giva Yeer or Deta:	s? <b>X</b> No		Was Decedant f Yes, specify ( I ☐ Yas 2 💢		(Specify Yas or No- erto Ricen, etc.)		e - Amaric ck, White,		
	3	15. Decedent (Specify only highes			16e. Deced	lent's Usuel Oc	cupetion na during most of w	mekina	16b. Kind of Bu	siness/Ind	dustry	
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10		DR. MATTHEW		DEB	USKEY		MA	RGARET		LOI	SB	
		19e. Informent's Neme/Reletions	nip (Type, Print)	9"	19b. Meilin	ig Address (Sti	eet end Number or	Rurel Route Number	, City or Town,	Stete, Zip	Code)	
injury or other t	1	FRANCOIS P. DEF  20a. Method of Disposition  1  Burial 2  Cremetion  4  Donetion 5  Other (Sp.	3 □Removel from Sta	20b. Pie	natery, cren	HALTER sition (Neme on etory or other P SERV.	pleca)	TMINSTER, Data 10/10/97	MD 21 20c. Location -			
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Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)  Sequentially list conditions, if ery, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in deeth) Lest	b	Due to (or o	es e conseques e conseques e conseques	uence of):	KLAK	10 IMA			<i>39!</i>		
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d be detached for us		Pert II. Other eignificant conditio	ne contributing to death	but not result	ing In the ur	nderlying ceuse	given In Pert I.	23b. Dld to	es 2 No		the cause o	
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Com								1 🗆 Ye	es 208-Ho	1[	Yes 2	No
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5 5		examiner?	Hospital: 1 ☐ Inpe	etient 2 E	R/Outpetien	t 3 DOA	Other: 4 Nursing	Home 5 Reside	ence 6 Othe	ar (Specify	()	
ion:	27. Menner of Deeth  Natural 5 Pending 2 Accident investig	ation	jury 2 Dey Yeer) 2	8b. Time of Injury		njuryat Work? I ☐ Yes 2 ☐ No	28d. Describe ho	ow Injury occurr	ed			
Certification:		3 Suicide 5 Sould in deferred	288. Piece of I	Injury - At hom etc. <i>(Spacify)</i>	na, farm, stre	eet, factory, offi	се	28f. Location (St City or Town	reet end Numb n, Steta)	er or Rure	l Route Numb	ber,
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O	1 23	30. Name end address of person v	no completed ceuse of	f deeth (Item 2	23a) (Type, I	Print)	11 /1/2	1 /	nin	211	0	
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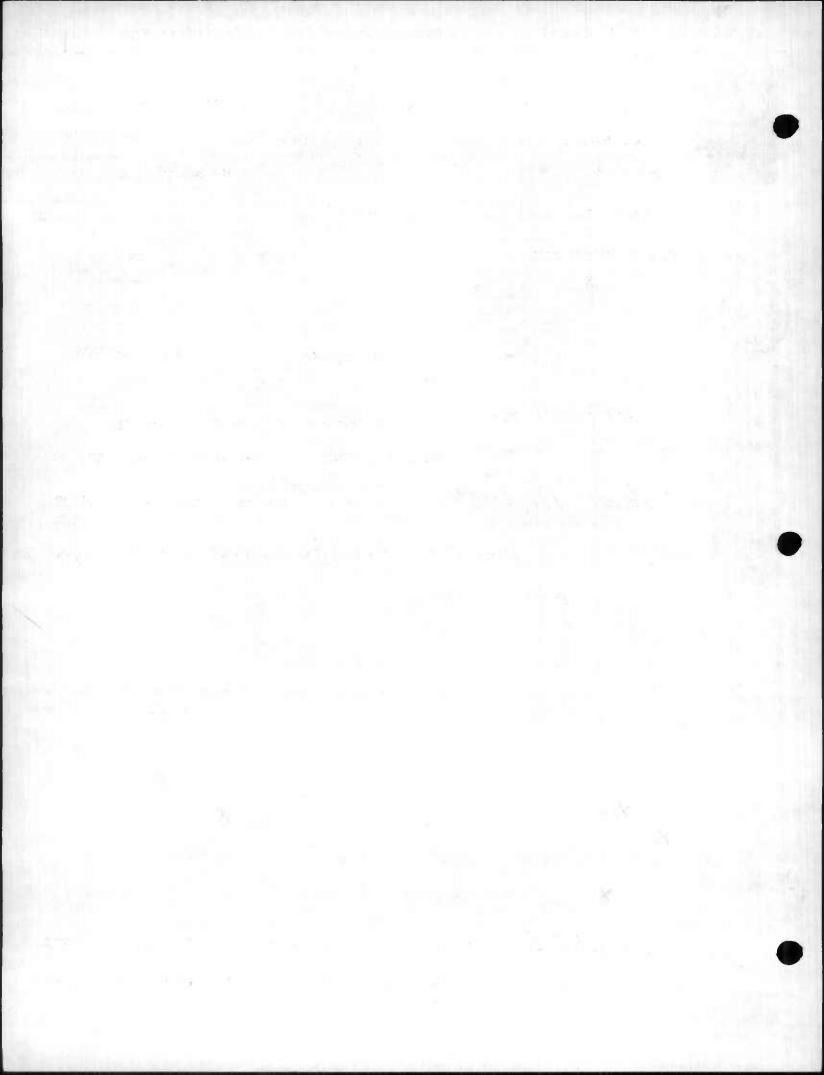
#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 8, 1997 ear DAGOLD DONALD 9am /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE 8321 STEVENSON ROAD | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | 9. Birthplace (State (Month), Dey, Year) | MAY 30, 1933 | MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 64 213-30-1844 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Ineide City Limits MARYLAND BALTIMORE BALTIMORE 1 ☐ Yes 2 No Director must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? THE 23s 8321 STEVENSON ROAD 21208 USA 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) PHARMACEUTICAL PHARMACIST altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) of and Mental A Be **GEORGE** DAGOLD SARA MAZER 2 Department of Health and I Important: if Hem 27 is mainty Injury or 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. AUDREY DAGOLD /WIFE 8321 STEVENSON ROAD BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 10-10-1997 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Sol Levinson & Bros., Inc. uch 8900 Reisterstown Road Pikesville, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in deeth) adenocarcinona /Medical 248415 Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760, 8 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 25 No 3 Probably 4 Unknown signed I Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peed certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 \ Homiclde 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number Marshall a. Thrine, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dt. Mars WILA. Levine 4000 Old Court Rd. Suite 306 Baltimere, MD 2/208 31. Date filed (Month, Day, Year) OCT 14 1997

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Henry E, Dean 09:00 AM 1997 4a. Facility Neme (If not Institution, give street and number)
Union Memorial 4b. City, Town, or Location of Deeth Baltimore 4c. County of Death if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 4726. Sex 220-03-1472 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 17 M 20 F Yrs. Feb 5, 1919 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits N/A Baltimore Yes 2□No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4335 Newport Avenue 21211 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? X Y Y Yes, Sive Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2/7 Married 1 Yes X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) In surance Life 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Leon Dean Mary Chaney 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Dean (Wife) 4335 Newport Avenue Balto, MD 21211 20b. Place of Disposition (Name of cometery, crematory or other place)
Meadowridge Mem Park 10/13 Dorsey, Maryland 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Fecility Burgee-Henss Funeral Home 3631 Falls Rd. Balto, MD or complications that ceused the death. Do not enter the mode of dying, such es cardiac or raspiretory errest, List only one cause on each line. Approximete Interval Betw Onset and Deeth Immediate Cause (Final Infavotion Myscardial disease or condition resulting in death) Ischemic Cardiomyopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Smoking veavs Due to (or as e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? 1 108 2 No 3 Probably 4 Unknown Chronic obstructive permonary disease, coronary 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? outery disease, congestive heart failure, peripheral Vascular disease, long term shortness of breath

25. Wes case referred to medical examiner?

1 Yes 2 No Hospital: 1 Mapatient 2 TEP/Outsite Control Other: 1□ Yes 20 No 1 ☐ Yes 2 ☐ No 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

6

238

items :

filed within 72 hours after of Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any Injury or other traumatic event

21215-0020

Baltimore, Maryland

the Medical Examiner must be notified

Director

Funeral

PV

Completed

Be

Examiner Physician/Medical

Attor

Dear

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ŏ

10 State Registrar

Medical

Robert Blackman, I M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Year) OCT 14 1997

6 Could not be determined

2 Accident

3 ☐ Suicide

29e. Certifier

4 Homicide

29b. Signature and title of cartifier

Blackmon, IV M
par)

32. Registrer's Signature

Julia Auridson-Rendelle M.D.

1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

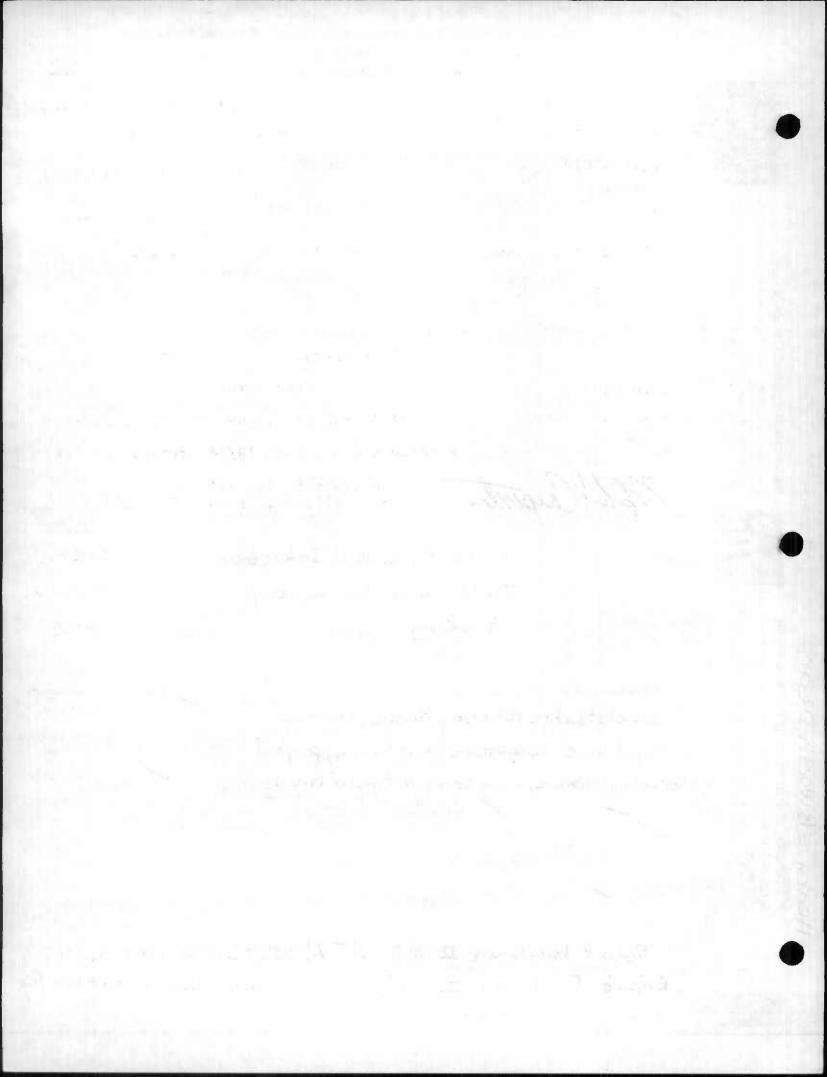
1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Dete signed (Month, Dey, Yeer)

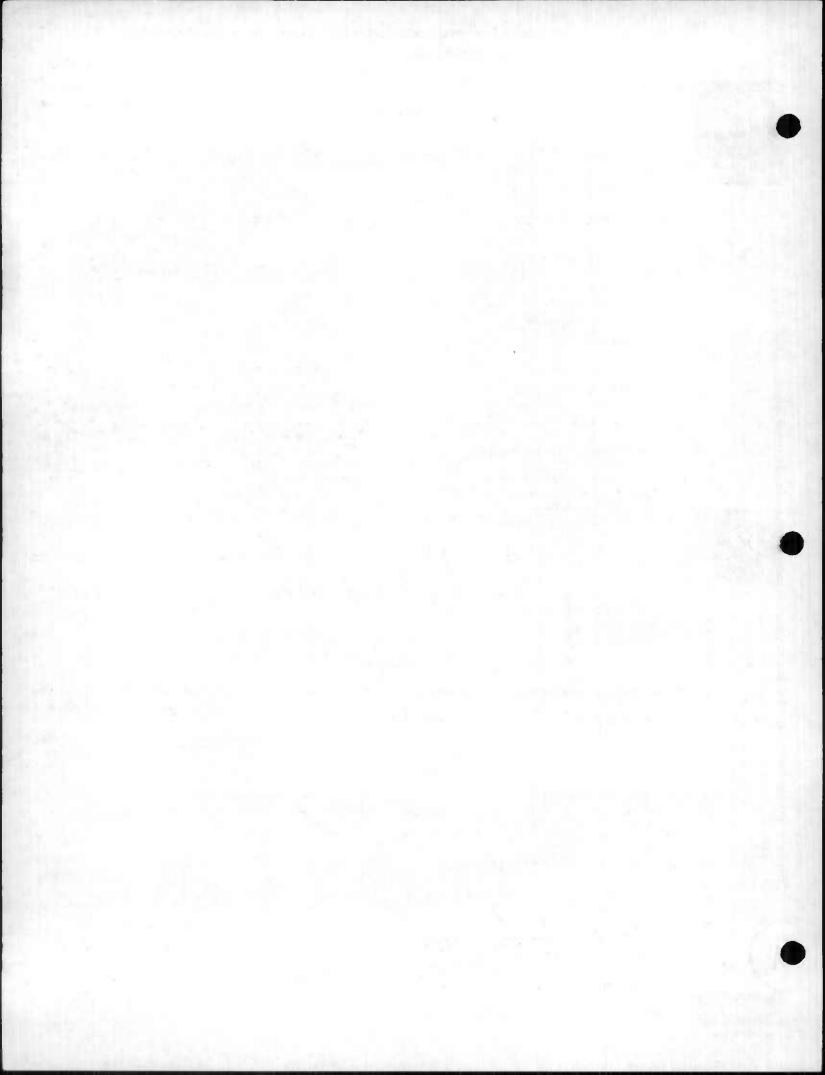
October 09, 1997 Union Momorial Hospital 201 E. Univ. Pky



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month Day **GERTRUDE ELLENBERGER** October 9, 1997 4:40AM /Medical 4a. Facility Neme (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** EDENWALD RETIREMENT COMMUNITY
Security Number 6. Sex 7. Age (In yrs. last birthday) Towson II Under 24 Hrs. Baltimore County

9. Birthplace (State of Foreign
Country) If Under 1 Year Months Days 5. Social Security Number 8. Dete of Birth (Month, Day, Yaar) **Funeral** Days Hours 1□M 24F 216-24-8069 Yrs. Director 89 Maryland Mar 2, 1908 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylai th end Mental Hygiene.
7 is marked other than "natural", or itama 23a or 28a4 shoy traumatic evant, the Medical Examiner must be notified at 28a-f show Maryland Baltimore County 1 ☐ Yes 2√ No Director Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road Funerai 21286 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0020 à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary Civil Service 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Be 1º George J. Ellenberger Schilling 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Streat end Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 Depertment of Health el Important: If item 27 is any injury or other trau 409 Washington Avenue, Towson, Maryland 21204 of Disposition (Name of Date 20c. Location - City or Town, State Louis Friedman, Esq. 20b. Plece of Disposition (Name of cematary, crematory or other plece) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory
22. Name and Address of Fécility 10/11/97Baltimore, Maryland Martin D. Lawson Mitchell-Wiedefeld Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Acute Myocardial Examiner Examiner 3 years The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, ettending physician for use es the buria Physician/Medicai Due to (or as a consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Heart þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? hes 2 No certificate 1 ☐ Yes 2 ☐ No or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Directors the 6 Could not be determined 3 ☐ Suicide 28f. Location (Streat and Number or Rurel Route Number, City or Town, Steta) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Spacify) in by 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. Medical (Check only one) 2 | Medicar Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) and menner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 7600 Osler#311 Towson Molarzo4 ohn 31. Date filed (Month) Dey, Yaer) State Registrar



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth October 12, 1997 **Physician** ANNF WENGER 6:25AM /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Genesis Multi Medical Towson Baltimore if Under 1 Yeer 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foraign Country) **Funeral** Deys Hours 1 □ M Yrs. Director 220-30-6448 101 August 5,1896 Switzerland Usuel Residence of Dacedant the Maryland 10b. Count 10a State 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 734 East Lake Avenue 21212 deeth USA 12. Was Decedent Evar in U,S. Armed Forces? 1 Yes XX No If Yas, Give Yeer or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours effer nent of Health and Mantal Hygiene. nt: If item 27 is marked other than "natural", or ite 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes XX No by Specify: XX Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Gottfried Wenger Anna Kuntz 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda) 734 East Lake Avenue Baltimore, Maryland 21212 ca of Disposition (Neme of Deta 20c. Location City or Town, Steta Elizabeth Evans Carr other t DTR 20e. Method of Disposition

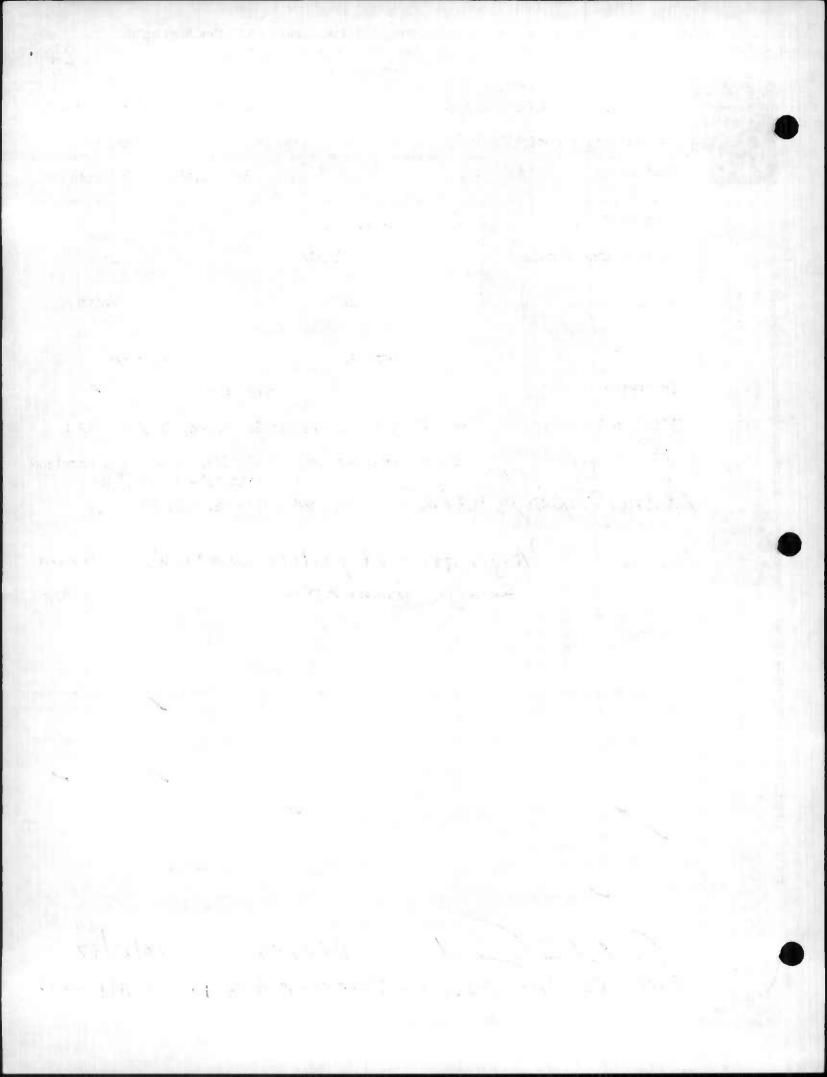
1XXBurlal 2 Cramation 3 Ramoval from Stete 20b. Pleca of Disposition (Neme of cametery, crametory or other pleca) 20 Donetion 5 Other (Specify) Druid Ridge Cemetery 10/15/97 Pikesville, Maryland gnetura of Funerel Service 22. Nama and Addrass of Fecility Mitchell-Wiedefeld Home Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, applications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, and provided in the cause of the deeth. Approximeta Interval Between Onsat and Daath **Physician** /Medicai Immadiata Cause (Finel e. Aspiration of gastric contents

Dua to (or as e consequence of):

Dua to (or as e consequence of): disease or condition resulting in death) Examiner sloian and burial-transit Sequentielly list conditions, if eny, leeding to Immediate causa. Enter Underlying Ceuse (Diseasa or injury that initiated events rasulting in deeth) Lest Dua to (or as a consequence of): P.O. Box 68760, attending physician for use es the buria Physician/Medical Dua to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 2 No 3 Probably 4 Unknown Records, by 9 24b. Wara eutopsy findings evailable prior to completion of causa of death? 24e. Wes an eutopsy performed? Completed peed page 2 certificate has 2 13 No 1 ☐ Yes 2 No Division of Vital Be 25. Wes casa ratarred to medicel axeminer? 26. Piece of Deeth (Check only one) Othar: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menne of Death 1 PNatural 28e. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After the Hospital or Attending I hin 24 hours after death. The Funeral Director: After 5 Panding Investigation 1 Tyes 2 No 2 Accident 6 Could not be datermined 3 ☐ Suicide 28e. Pleca of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, State) P 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceusa(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceusa(s) and menner stated. Medical pletely (Check only 29b. Signeture and title of cartifian 29c, License number 29d. Data signed (Month, Pay, Year) 020688 30. Name end eddress of person cause of deeth (Itam 23e) (Type, Print) Fairmount Ave, Towson, Mdr 21286 s. Friedman arl 32. Registrer's Sig 31. Date filed (Month, Day, Year) State 1 4 1997 Registrar

DHMH 16 Ray 6/95



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								tificate of	Death		Reg. No.	300	525
п	Physic	ian	Decedent's Nema (First, M.							2. Date of De	Dey/()	Yaar C	3. Time of Death
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ш	Funeral		5. Social Sacurity Number	6. 5	M 2□F		yrs. last birthday)  7 Yrs.	ff Undar 1 Year Months Days		8. Data of Birt (Month, De	h v, Year)	9. Birthplace Country)	a (Stata or Foraign
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			Steven Freen	nan/	Son		505	W. Ben	forest F	Road, S	everna	Park	. Md
ore	of He ltem		20a. Mathod of Disposition			2	20b. Place of Dispo camatary, cran	sition (Nama of	ica)	Data	20c. Location -		
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Baltimore,	permit. Peges 1 and Department of Health Important: If Item 27 any injury or other to		21. Signature of Funeral Sep	foe Liger	1500 /	1	9 22	. Nama and Addr	ass of Facility			POZZE	7
m	Depermination of the population	1 Natruk	1	11.	1/1	Ha	ardesty	Funeral	Home,	P.A.			
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	the att	sicie	Part II. Other significant con	ditions c	ontributing to de	ath but no	ot rasulting in the ur	nderfylng cause gi	van In Part I.	23b. Dld 1	obacco use co	ntribute to the	e cause of death?
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			27. Mannar of Death  1 Natural 5 Pa 2 Accident	nding estigation		of Injury th, Day Ye	28b. Tima of Injury	M 1	ry et ork? ] Yes 2 □ No	28d. Describe t	ow injury occur	red	
Division	al or Attend s after death il Director: /	Certification:		uld not be arminad	28a. Placa	of Injury - ng, atc. (S	At home, ferm, strapecify)	aat, factory, offica		28f. Location (S City or Tox	Street and Numb m, Stata)	per or Rural Ro	outa Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai			niner: On the bo		minetion and/or inv	restigetion, in my	ima, deta and place, opinion, deeth occur				
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	10			eon who			(Item 23a) (Type,	Print) ANMA	ous us	2140	11		
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Registrar

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State of Maryland / Department of Health and Mental F	lygiene 7	30	8	2	C
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Certificate of Death	Reg. No.				

**Physicia** /Medic Examin

Funeral

Director thems 23s or 25s-f show our must be notified at

Baltimore, Maryland Physician /Medical

been signed by the ettending physician and should be detached for use as the bunal-transit

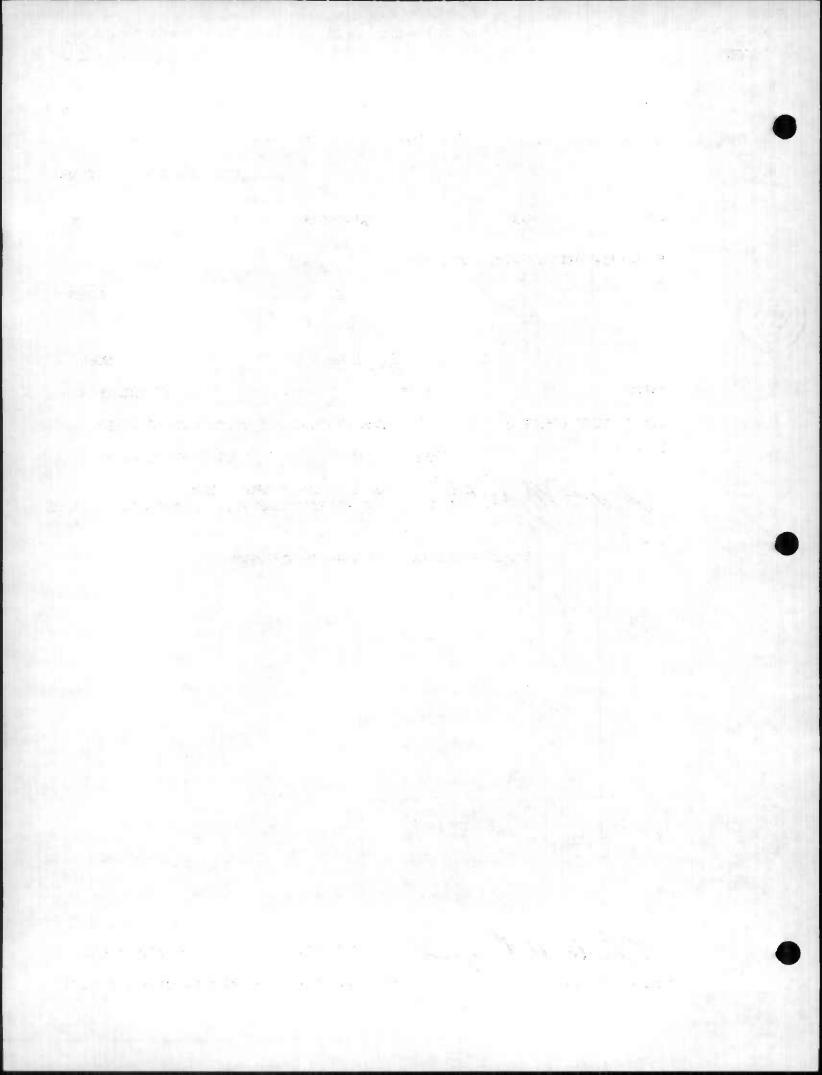
Examiner To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

SIDNEY		asi)			FINK				Month  CTOBER	Dey	Year	3:30P.M.
4a. Fecility Neme (/	f not institution, gi	ive street and number)					4b. City, To		cation of Death	1	y of Death	3:30P.M.
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5. Sociel Security N 212–18–7		Sex 7. Age 1	76	Yrs.	If Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, OCT . 2	Year) 9, 192		plece (State or Foreigntry) RYLAND
Usuel Residence of												
10a. State	10b. County		10c. City, T	own or Lo							1	10d. Inside City Limit
MD		N/A				TIMO	RE					1 X Yes 2 No
10e. Street end Nur	mber				10f. Zip	Code			1	0g. Citizen of	Whet Cour	ntry?
	ARK HEIG	HTS AVE.,	APT. 9	04			21215			US		
11. Marital Status	ed 2 Merried	12. Was Decedent I Armed Forces?		13.	Was Deced If Yas, spec	dent of F cify Cuba	lispanic Ori an, Mexicar	gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)		ca - Americ ck, White,	
3 Widowed		1 Yes 2 N If Yes, Give Year or Datas:	10		1 ☐ Yes	2 XN0	Specify:			Speci	fy:	WHITE
	15. Decadent's E	Education		6a. Dece	dent's Usua	ai Occur	ation			16b. Kind of E	Susiness/In	dustry
(Speci	ify only highest gr	rade completed)		(Give	kind of wo	rk done	during mos	t of worki	ng			
Elementary/Seco	ndery (0-12)	College (1-4or 5	+)		N	ONE-					3.7/	ONTE
17. Father's Name	/First, Middle, Les	t)			TA	OIVE-	18. Mothe	r's Name	(First, Middle, M	faiden Surna	me)	ONE
AARON			F	INK			TIL	LIE		FTNI	KELST	ETN
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20e. Method of Disp		☐Removai from State	20b. Piace	e of Dispo	sition (Nan	ne of ther plac	ce)		Date	20c. Location	- City or To	own, Stete
	5 Other (Speci				ZION			10/	9/97 I	ROSEDAI	E, M	D
21. Signature of Fu	erei Service Li	ороо, /	110	22	2. Neme en	d Addre	ss of Facilit	У				
1	off	M. LUX	AHI						S., INC.			
disease or condition resulting in death)		b	Due to (or es	e consec	quence of):	ovas	cular	Dise	ease			
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3 ☐ Suicide 4 ☐ Homicide	6 Could not to determined		ry - At home . (Specify)	, farm, str	eet, factory	, office		2	28f. Location (St. City or Town		ber or Rure	al Route Number,
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State Registrar 31. Date filed (Month, Day, Year) QCT 1 4 1997



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month Yaar HELEN. FRANCES FRANKTIN OCTOBER /Medical 1997 11: 06 pm 4a. Facility Nama (If not institution, giva street and number) 4b City Town or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 M 2 XF Yrs. 76 Director 014-18-1227 1920 Massachusetts Nov. 11, Usual Rasidence of Decedant 10a. Stata 10b. County 10c. Cltv. Town or Location 10d. Insida City Limits must be notified at 1 TYas 2 □ No Directo Maryland N/A Baltimore 288-1 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8 thems 23a 6225 York Road 21212 U.S.A. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Was Decedant Evar in U,S. Armed Forces? Biack, Whita, atc. 1 ☐ Yas 2 ▼No ff Yas, Giva 1 Navar Married 2 Married 'natural', or 1 ☐ Yas 2 ☐ No Specify þ 3 Widowed 4 Divorced Yaar or Datas: White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Coliaga (1-4or 5+) Elamantary/Secondery (0-12) 12 years Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be 8 Pages 1 and 2 should 2 Mary Ann Walsh Michael Reidv 19a. Informant's Name/Raiationship (Type, Print) 19b. Malling Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) . Atment of Hear 27 by ortant: If hem 27 by 504 Dunkirk Road Baltimore, Joan Ports (daughter) Maryland 21212 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Ty Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 DOthar (Specify) 10-10-97 Pikesville, Maryland Druid Ridge Cemetery 21. Signatura of Funaral Sarvica Licansee 22. Nama and Addrass of Facility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 Part 1. Entar tha disaasa, or complications that ceused tha death. Do not antar tha mode of dying, such as cardiec or respiretory errest, hock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Death Physician /Medical Immediata Causa (Finai USUAL INTERSTITIAL FIBROSIS 3-4 months disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of): YEARS COPD physiclan and s the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated evants resulting in daath) Last Dua to (or as a consequence of): YEARS SMOKING Physician/Medical Dua to (or as a consequance of) 4-6WKS PNEUMONIA SUPERIMPOSED signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? complation of ceuse of death? page 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate 25. Was casa rafarrad to medical Be 28. Place of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 1 1 Inpatiant To 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred Certification: 28b. Tima of 28c. injury at Work? After 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accidant 3 Suicida 8 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida

1 Certifying Physician: To the best of my knowledge, death occurred at tha time, dete end place, and dua to tha causa(s) end menner as stated.
2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated.

29c. Licansa number

29d. Data signed (Month, Day, Year)

DO052279 10/10/97

The law requires that the death certificate be asscuted P.O. Box 68760. Division of Vital Records. Attending Physician: of Attendings after death. Hospital

: Franklin,

Within 24 hours a To the Funeral C completely filled edical 1 State

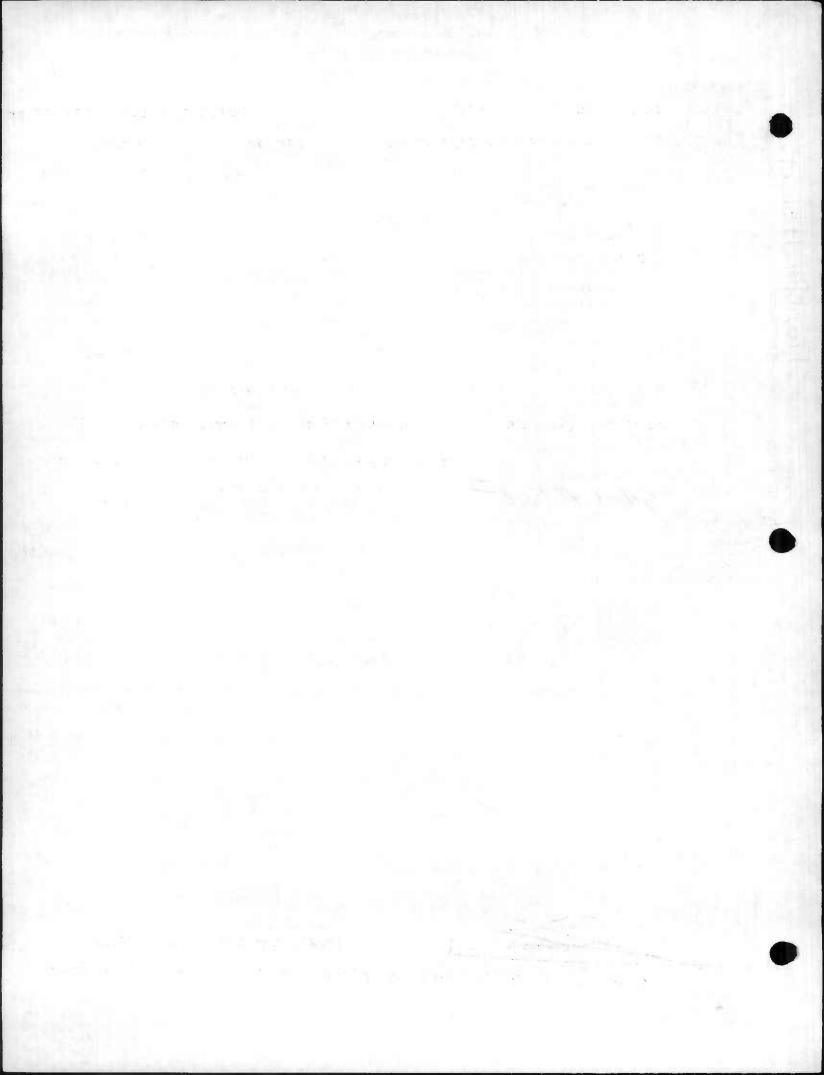
31. Data filed (Month, Day, Year)

29b. Signatura and title of certifiar

29e. Certifian

30. Neme and addrass of person who complated cause of death (Item 23e) (Type, Print), 2825 GBMC 6701 NCharles Sweet, 32. Registrar's Signatura helia Davidson-Bondasse

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30828 Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth KIODE 4c. County of Deeth 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Randallstown Baltimore Northwest Hospital Center | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Min. | March 16,1910 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2√2 F 87 214-01-0910 Yrs. Balto. Md. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Owings Mills 10e. Street end Number 10f. Zip Code 10g. Cifizen of What Country? 11 Byway Road 21117 USA 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bieck, White, etc. 11 Maritel Status 1 Yes 2/No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ◯XNo Specify: 3℃eVidowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Salesperson Retail Store 6 th Grade 17, Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Frank Schirmer Anna Demling 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan A. Heiland (Daughter) 11 Byway Road Owings Mills, Md. 21117 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation Service 10/13/97 Hampstead, Md. 21. Signature of Funerel Servige Licenses 22. Name end Address of Fecility 11824 Reisterstown Road ELINE FUNERAL HOME amo lim Reisterstown, Md.21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tellure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) 850 × 10 Due to (or es e consequence ot): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequença of): Due to (or es e consequenca of) Pert II. Other significent conditions contributing to death but not resulting In the underlying cause given in Part I 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were eutopsy tindings eveileble prior to completion of cause of deeth? 8 1 ☐ Yes 2 XNo 8

**Physician** /Medical Examiner

27

mportant: If 8

other

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**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

items 23a or 28a-f show lical Examiner must be notified at

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Baltimore,

Pages 1

Director

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10

Examiner buriel-transit Physician/Medical

pue ettending physician the signed by the et id be detached fo been : hes this certificate f or Attanding Physician: offer death.

Director: After this certifications director, in by the 24 hours Medicai To the Hosp within 24 hou To the Funer completely fil

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

Hospital

State Registrar

þ Completed Be 25. Wes case referred to medical, examiner? 0 200 No 1 Yes Certification: 27. Menner of Deeth Naturel 2 Accident 5 Pending investigation 3 Suicide 6 Could not be determined

29b. Signeture end title of

4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

1 Inpatient ER/Outpatient 30 DOA

28e. Dete of Injury (Month, Day Year)

Injun 28e. Pleca ot Injury - At home, farm, street, tactory, office building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 Ves 2 No

26. Place of Death (Check only one)

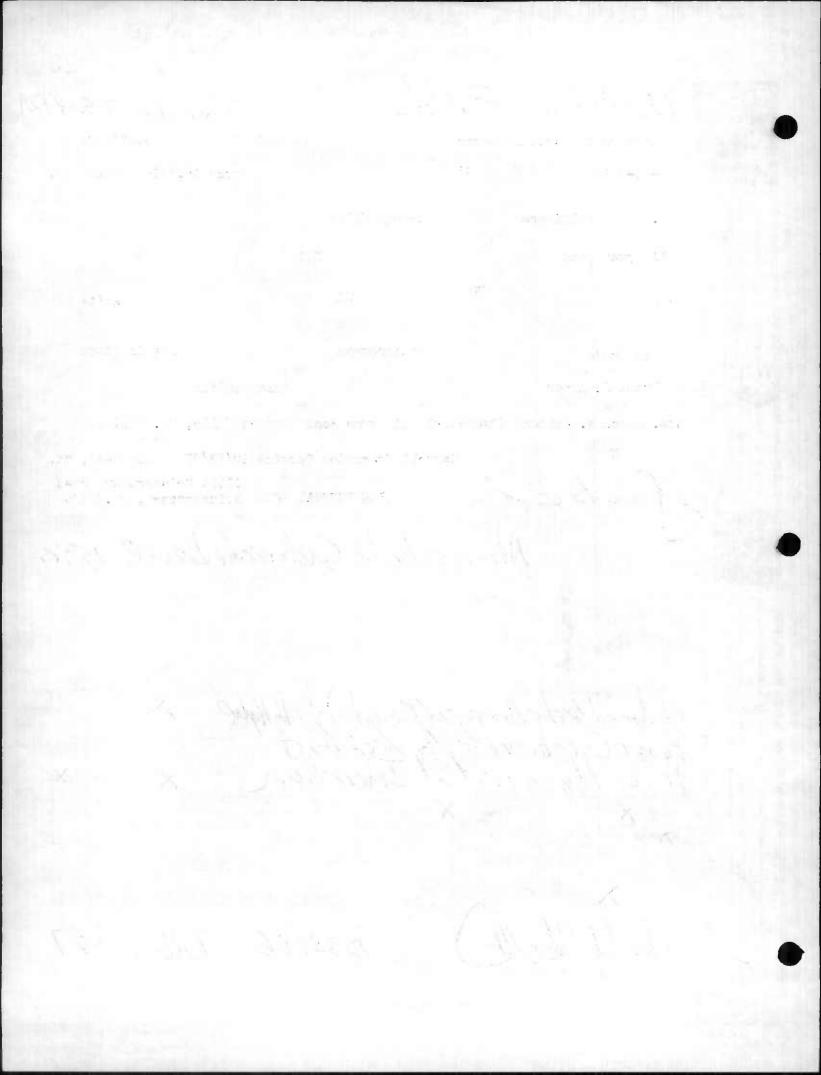
28t. Location (Street and Number or Rurel Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the causa(s) and minimum as a subset.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the causa(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)\_

30. Name and address preprising on the ted Wis Direct ath (Item 23e) (Type, Print)

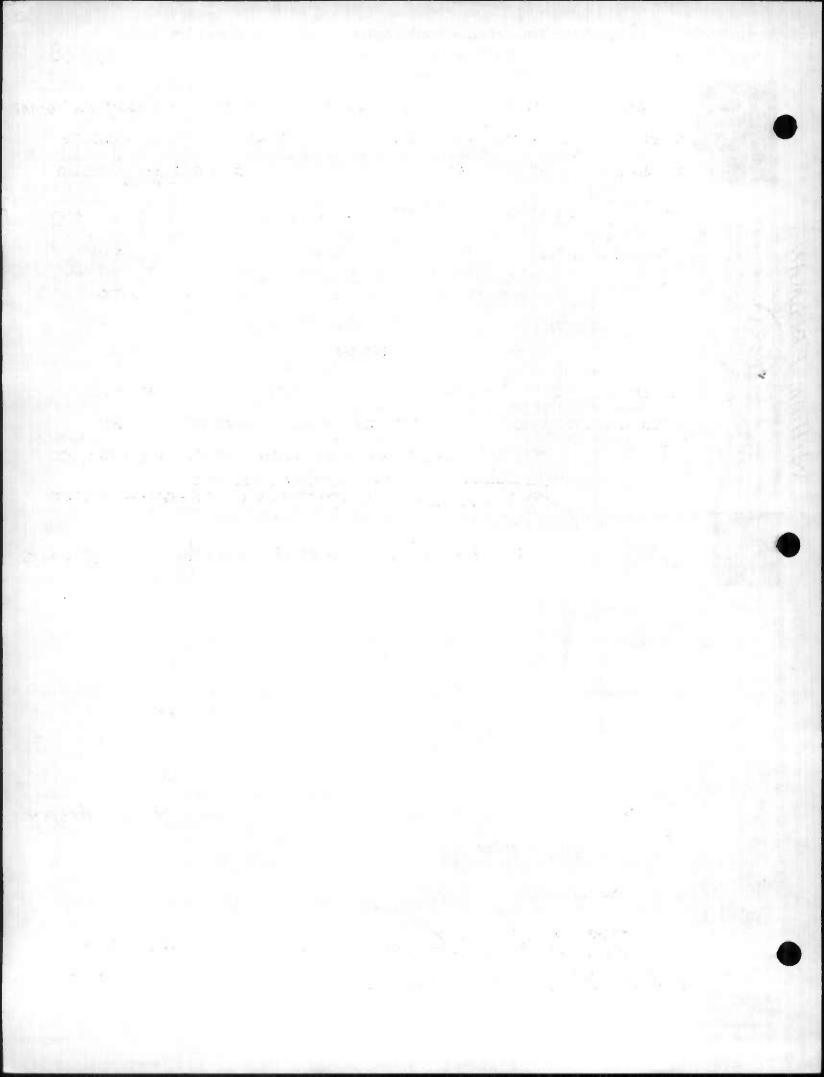
39. Registrar's Signal Candalla.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 3 3 3 2 9

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Lipy Funeral		Marital Status     Mevar Married 2     Widowed 4		12. Wes Dece Armed For 1  Yas If Yes, Give Yaer or Da	ces? 2 No	U,S.			t of Hispani Cuben, Me		ecify Yas or No Ricen, etc.)		ce - Amarican II ck, White, etc. WHITE	ndian,
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certificate has rector, page 2 Be Comp											101	res 20 No	1 ☐ Ya	s 2 No
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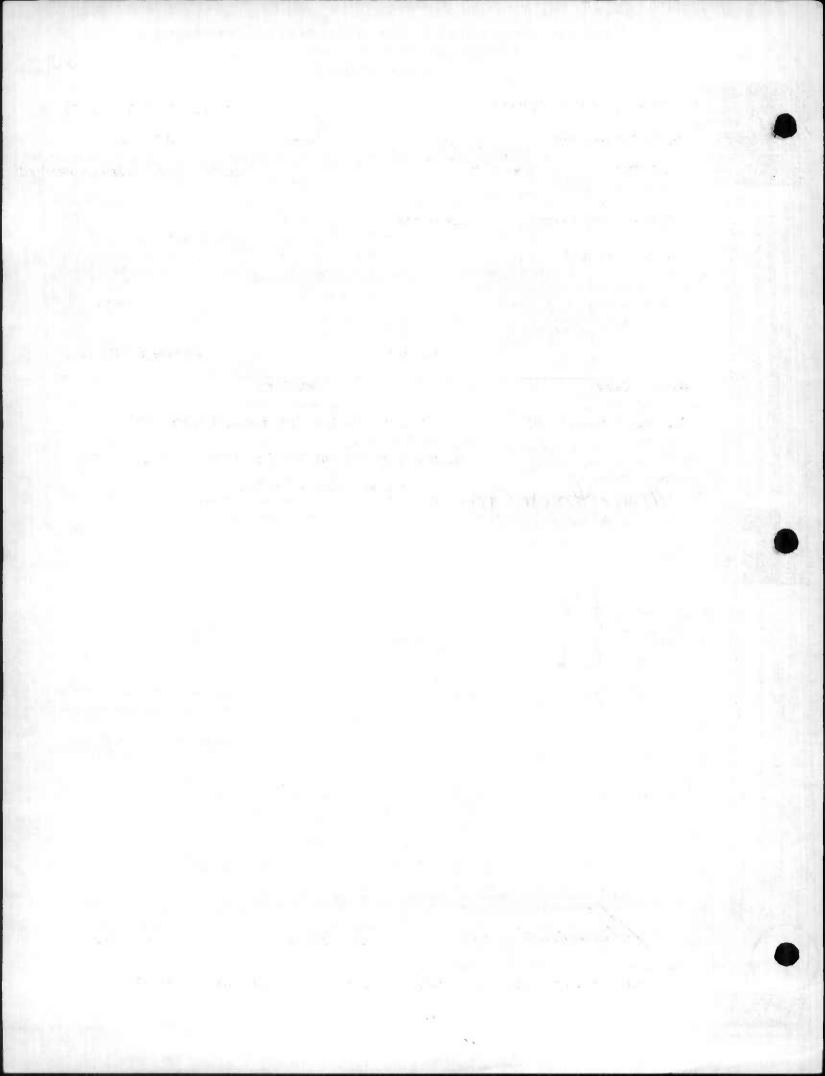
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State of Maryland / Department of Health and Mental Hygiene 7 30830

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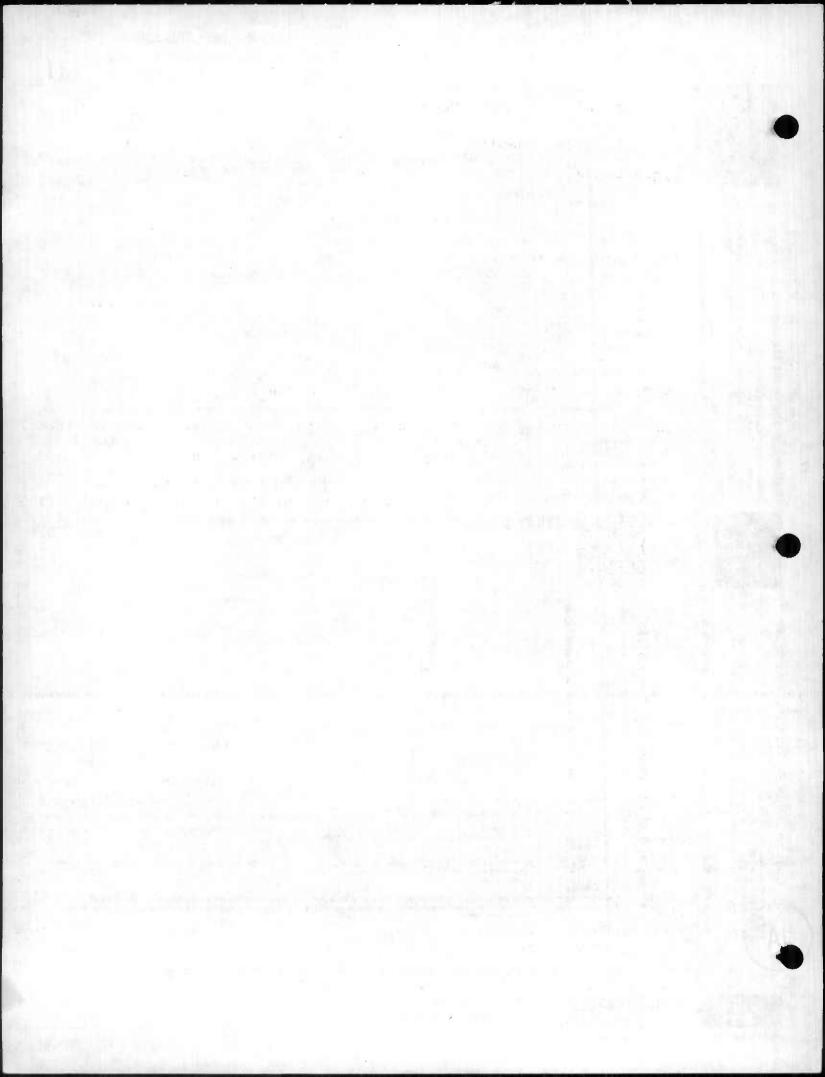
NAME: CATHERINE FORTMAN



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedant's Name (First, Middla	Last)					2. Data of D	Reg. No. eath	Yaar 3.	Tima of Daatt
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r items 23a or 28a-f show inter rust be notified at Funeral Director	200	302 East LAn	12. Was Dece		118 12 1	2120		Pagity Van ar N	USA	ce - Amarican Ir	ndina
Department of Haelth and Mental Hygiane, important: If items 23a or 28a-f show important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Dy run	1 Navar Married 2 Marrie 3 Widowad 4 Divorcad	Armad Fo	rcas? 2⊠ No a		Vas Dacedant of I I Yas, specify Cub I □ Yas 2 No		to Rican, atc.)	Bla Specif	ick, Whita, atc.	
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 7 per FH Film G754 12-08-97 rja Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey **Physician** Month Dora Gill 6:33pm 10, 97 October /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** 4406 Moravia Road Apt. Baltimore If Under 1 Yeer | If Under 24 Hrs. Months | Devs | Hours | Min. 7. Age (In yrs. last birthday) 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) **Funeral** 1□M 2□F Yrs Director 212-18-4660 11-12-08 NC Usual Residence of Decedent with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 Yes 2 No Director Md. NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4406 Moravia Road Apt.#7 21206 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Reca - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours efter or eat of Health and Mental bygiene. int: If Item 27 Is marked other than "natural", or itel iny or other traumatic event, ma Medical Especials. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: by Specify: 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 8th Grade Domestic in & out of home NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Ben Joseph Wilkerson Jenny 19e. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 permit. Peges 1 and 2 s Department of Heatth er Important: If Item 27 is any injury or other trau Mary Gill 4406 Moravia Road Apt. #7 Baltimore, Md. 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete N☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Cemetery 10-14-97 Baltimore, Md. 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee Baltimore, Maryland 21202 Karen m. Foger WM.C.March FH 1101 E. North Avenue 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** bro Vascular Accident /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner sertension physician and s the burief-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings evalleble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? pege 2 s 1 ☐ Yes 2 No 1 Yes 2 No certificate Division of Vital to or Attending Physician: The state death.

It Director: After this certificated in by the funeral director, pe Be 25. Wes case referred to medicel exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2000 Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Neturei 5 Pending investigation 1 Yes 2 □ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and menner stated. Medical 29e. Certifier one 29b. Signa 29c. License number 29d. Date signed (Month, Dey, Year)

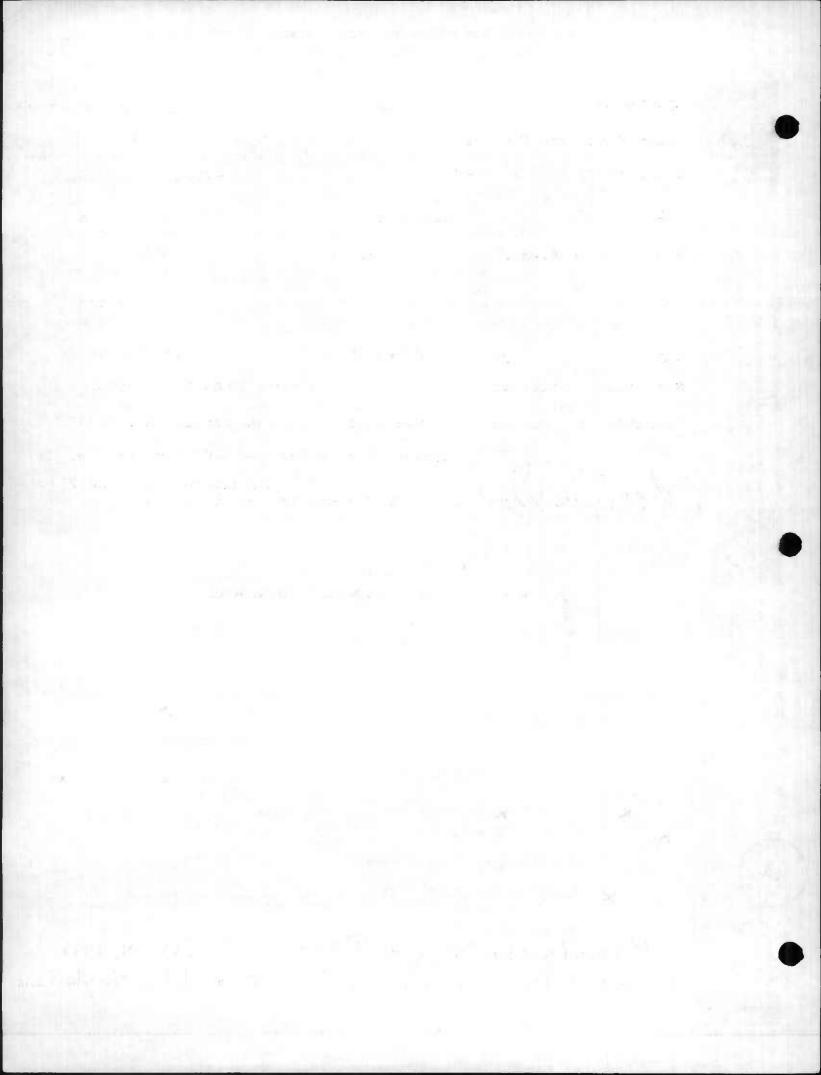
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32. Registrar's Sign
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nning 900 3000 32. Registrate Signeture Julia Davidson-Randell Wyman Park Por

completed ceuse of deeth (Item 23a) (Type, Print)

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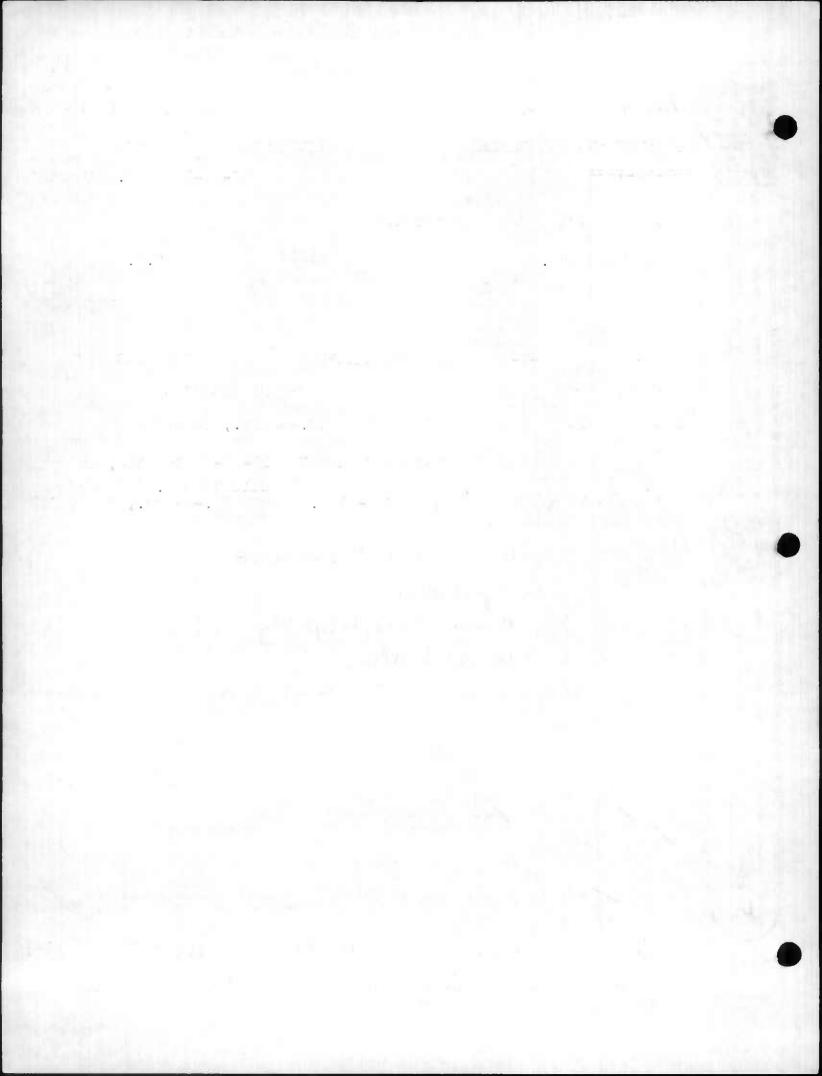
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William   Pemberton   Pembet	Con	G	ED		NA		Dom	estic					vario	ous t	rades
19a. Informer's Name/Relationship (Type, Print)   19b. Melling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)   21 North Avenue Baltimore, Md. 21202   20b. Method of Disposition (Name of Committee)   20b. Date of Disposition (Name of Disposition (Name of Committee)   20b. Date of Disposition (Name of Disposition (Name of Disposition (Name of Disposition)   20b. Date of Disposition (Name of Disposition)   20b. Date of Disposition (Name of Disposition)   20b. Date of Disposition (Name of Disposition)   20b. Date of Disposition (Name of Disposition)	Be														
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WM.C.MArch FH 1101 E. North Avenue  25s. First Erer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest.    Approximate characteristic cause (Fine) disease or conditions or cause (Consection)			XXBuriel 2 ☐ Creme 4 ☐ Donetion 5 ☐ Ott	er (Specify	0	Ce	metery, crei	metory or other	er piece)		10-				
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29b. Signature end title of certifier  Mohamed Kharfan Dabaja HD  Plossa  29c. License number  29d. Dete eigned (Month, Day, Year)  Oct 09, 1997  30. Name and edities of person who completed ower of death (Name Print)	To Be Completed by Physician/M	25. V e 1 27. M 1 2	Ves case referred to m xeminer?  Yes 29 No denner of Deeth red a colonial in the colonial in t	ending ending ending twe stigation ould not be	Hospital: 15(n) 28e. Dete of (Month)	petient 2 ☐ E Injury Day Year)	ER/Outpetler 28b. Time o Injury	nt 3□ DOA f 28c	Other: Injury e Work? 1 □ Ye	26. Piece e : 4□ Nurs	sing Hom 28	1   Y  24e. Wes a perfor  1   Y  (Check only or e 5   Resid ad. Describe h	neutopsymed?  es 2 No nee)  enca 6 Otto	3 Prob  24b. We ave con of d  1 mer (Specify	re autopsy findings illable prior to npletion of cause leeth?
29b. Signature end title of certifier  Mohamed Kharfan Dabaja HD  Plos89  29c. License number  29d. Dete eigned (Month, Day, Year)  Oct 09, 1997  30. Name and editress of person who completed cause of death (Nova 20) (Fines Pain)	To Be Completed by Physician/M	25. V e 1 27. M 1 2 3	Ves case referred to m xeminer?  Yes 2 No denner of Deeth Naturel 5 F Accident   F S Suicide 6 S	ending ending ending twe stigation ould not be	Hospital: 15(n) 28e. Dete of (Month)	petient 2 ☐ E Injury Day Year)	ER/Outpetler 28b. Time o Injury	nt 3□ DOA f 28c	Other: Injury e Work? 1 □ Ye	26. Piece e : 4□ Nurs	sing Hom 28	24e. Wes a perfor	n eutopsymed?  es 2 No ne) enca 6 □Ott ow Injury occur	3 Prob  24b. We ave con of d  1 mer (Specify	re autopsy findings illable prior to npletion of cause leeth?
Mohamed Kharfan Dabaja HD P10589 Oct 09, 1997  30. Name and address of person, who completed cause of deeth (Item 230) (Type, Print)	Certification: To Be Completed by Physician/M	25. V 6 6 1 27. N 1 2 3 4 4	Ves case referred to m xeminer?  Yes Case referred to m xeminer?  Yes Case referred to m xeminer?  Yes 20 No  Indian Indi	endical ending ending vvestigatior ould not be etermined	Hospital: 1 28e. Dete of (Month.) 28e. Plece o building ysician: To the basiner: On the bas	petient 2 Enjury Day Year) Injury - At hor of fniury - At hor of examinetic set of my know is of examinetic	ER/Outpetler 28b. Time o Injury ne, farm, sti	nt 3 DOA f 28c M reet, fectory, c	Other Injury e Work? 1 \sum Ye office	26. Piece c 4 \( \text{Nurse} \) 95 2 \( \text{Nurse} \) 0, dete end	o 28	24e. Wes e perfor  1 Y  (Check only or e 5 Resid ad. Describe h  St. Location (S City or Tow	es 2 No neutopsymed?  es 2 No ne) enca 6 Ott ow Injury occur treet end Num. n, Stete) euse(s) end m	3 Prob  24b. We ave con of d  1 mer (Specify rred	re autopsy findings illable prior to npletion of cause leeth?  Yes 25 No
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State of Maryland / Department of Health and Mental Hygiene 7 3083

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		LIBERTY MEDI					BALTIMO			A\N	
Funeral		5. Social Security Number 213-76-5291	6. Sex 7. A 1 M 2 T F	Age (In yrs. last i		If Under 1 Year Months Deys		(Month, Day,	Year)	9. Birthp	lece (State or Foreign
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	sic	Part II. Other significent condition	ne contributing to death	but not resulting	In the un	derlying cause gi	ven in Pert I.	23b. Dld tol	oacco use co	ntribute to	the cause of death?
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or Attending later death.	cat	2 Accident investig	not be	- A. A			Yes 2□No	206 Leasting (Oten			(David Mark)
Division of or attending Physical death. Director: After this of in by the funeral d	Certification:	4 ☐ Homicide determi	ned 288. Piece of II	etc. (Specify)	ierm, stre	et, factory, office		City or Town,		er or Hura	I Route Number,
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T A A	edical	(Check only 2 Medical I	Examiner: On the basis end menner s	of exeminetion e	nd/or Invi	estigetion, in my	opinion, death occ	urred et the time, da	te and plece,	end due to	the cause(s)
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1		30. Neme end eddress of person v	who completed ceuse of	depth (Item 23a	) (Type, F						-
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Kobert 03 **Physician** October 6, /Medical 4a. Facility Nema (If not Institution, give streat and numbar) 4b. City, Town, or Location of Death 4c. County of Daath Examiner BALTIMUKE

If Undar 1 Yeer | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 4 Aug. | 11, 1935 1213 MADISON AVE. 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** M 2DF Months Yrs. 219-32-9328 62 Director VA. Usual Rasidance of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Cifizen of What Country? 1213 MADISON AVE. 21217 Funeral IJ. S 14. Race - American Indian, Black, Whita, atc. 12. Was Dacedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Never Married 2 Marriad 1 ☐ Yas 2 No If Yas, Give X Yaar or Datas: 1 ☐ Yas 2X No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorcad BLACK Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry d 2 should be filed within 73 th and Mental Hygiena. Elamantary/Secondary (0-12) Collaga (1-4or 5+) -0-BOTTLER COCA COLA 17. Felher's Nema (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumame) WILLIE GOODMAN GLADYS WILLIAMS 19a. Informant's Name/Ralationship (Typa, Print) 19b. Melling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is I any Injury or other trau once. 2611 ALLENDALE RD.-BALTIMORE, MD GLADYS ASHBY 21216 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata Date 1 Donation 5 ☐ Other (Specify) MOUNT ZION 10/10/97 BALTO., MD 21. Signetura of Funarai Service Licensee 22. Nama and Addrass of Facility ELIZABETH L. PHILLIPS 1721-27 N. MONROE ST.-BALTO., MD. 21217 HECKON CESA lna 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physiclan** Immedieta Causa (Final disaasa or condition rasulting In daath) /Medical OF THE LUNG WITH METASTASET CARCINOMA 2 MONTHS Examiner Dua to (or as a consequenca of): Examiner Saquantially list conditions, if any, laading to Immediata causa. Entar Undarfying Causa (Disaasa or injury that Initiated avants resulting in daath) Last ğ Dua to (or as a consequence of) physician Physician/Medical 8 Dua to (or as a consequence of) ğ Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Onknown py 24b. Wera autopsy findings availabla prior to complation of ceuse of daath? Completed 24e. Wes en autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarrad to medical Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpalient 2 ☐ ER/Outpatlant 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Sother (Specify) HOSPICE 1 Yas 2 No Medical Certification: To 28e. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury et Work? Atter 1 Naturel 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 3 Sulcida 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and mannar as steted.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifian

29c. License number

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Teblow how.

and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

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29d. Data signad (Month, Day, Year)

BALTIMORE MD 2120

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Records, P.O. Box 68760.

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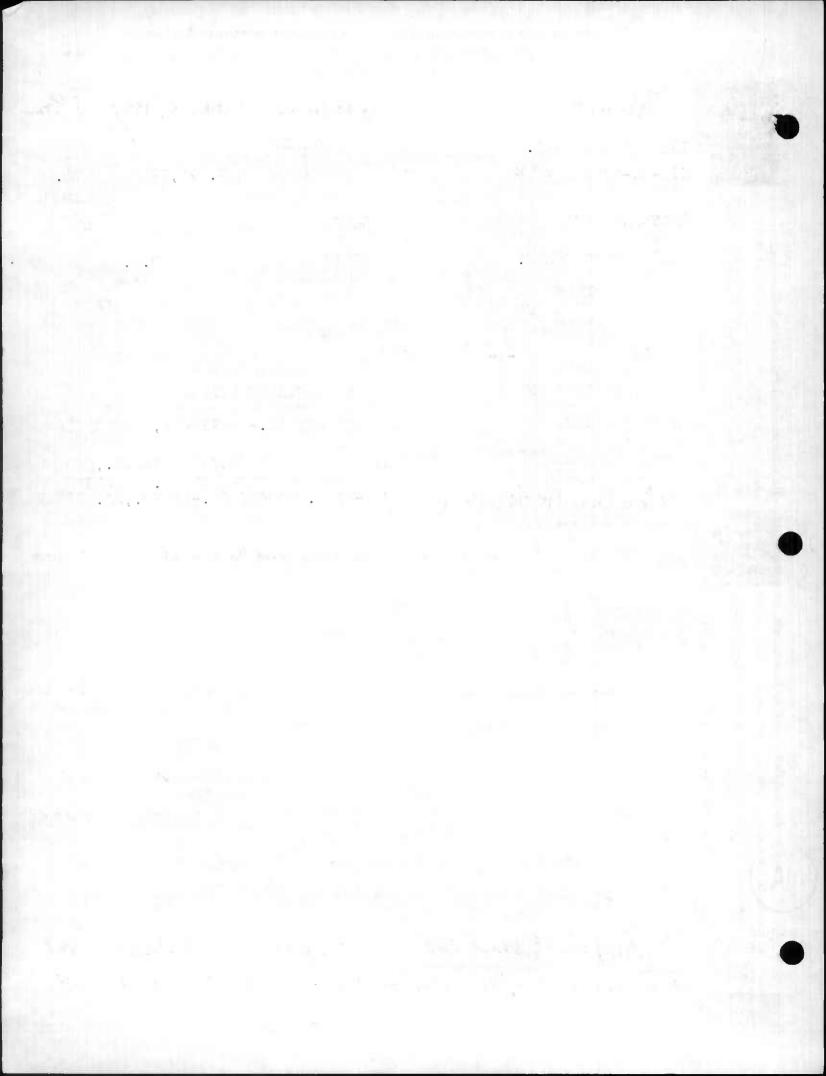
Baltimore, Maryland 21215-0020

State

Registrar

29b. Senature and title of certifier

3



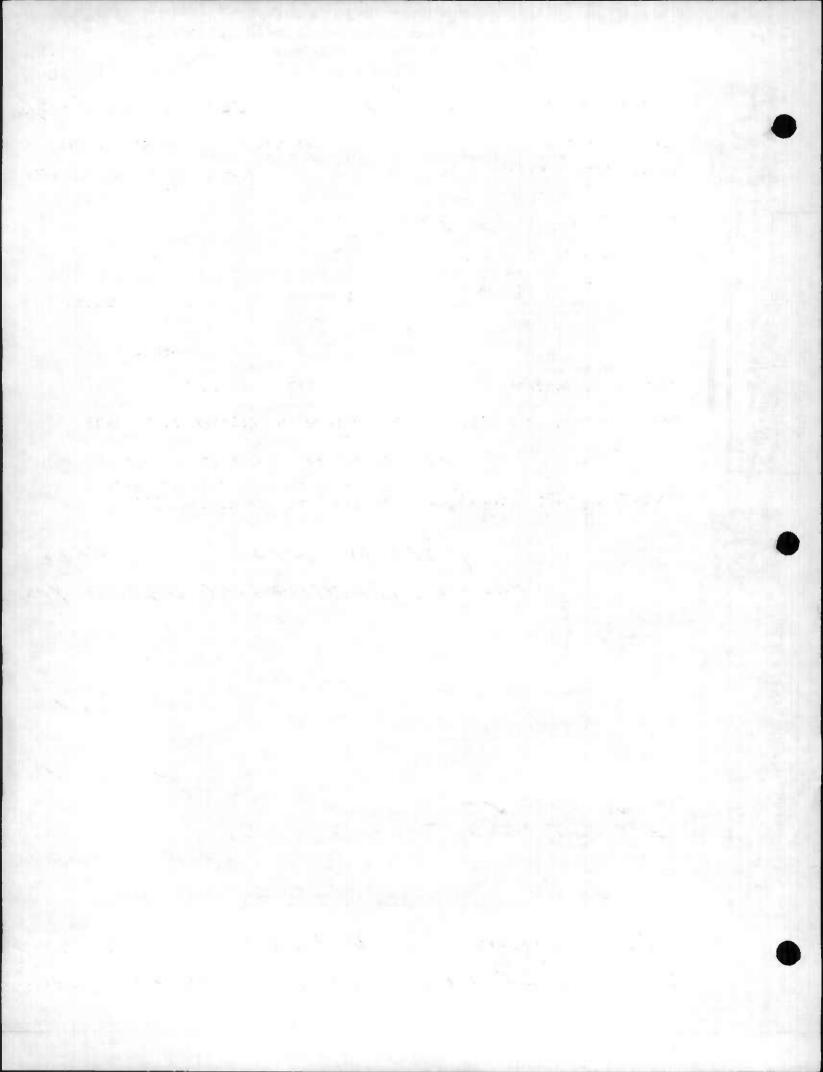
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth GARRET **Physician** CLARENCE /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Church Hospital Baltimore Baltimore City If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Funeral 100M 2□ F 215-16-2036 76 Yrs Director Apr 14 1921 Pennsylvania Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 ☐ Yes 2 XNo Dundalk 10e, Street end Number 10f. Zip Code 10g. Citizen of What Country? 1945 Sunberry Rd 21222 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ₭ Yes 2 □ No If Yes, Give Yeer or Dates: ₩₩ II 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Foreman Beth - Steel 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Charles B. Garrett Ethal Mae Post 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Garrett / wife 1945 Sunberry Rd 27 Baltimore, Md 21222 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Locetion - City or Town, Stete Date 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) Metro Crematory 10-14-97 Catonsville, Md 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 23a. Pert 1. Enter the disease, or complications that caused the doubt shock, or heart failure. List only one cause on each line. not enter the mode of dying, such es cardiac or respiretory errest **Physician** /Medical Immediate Cause (Finel PNEUM ONIA
bue to (or es e consequenca of): disease or condition resulting in death) Examiner OBSTRUCTIVE LUNG DISEASE Examine Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Box 68760 Physician/Medical Due to (or es e consequenca of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2₽No Vital 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 to 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: Division 1 Naturel 5 Pending Investigation 1 TYes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) B 4 ☐ Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner as steled.

2 Medicat Exeminer: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end manner steted. 29a. Certifier Medical (Check only one) 29c, License number 017322 29b. Signeture end title of cartifie

State Registrar ZEMI, M. CHUNCH GOSPITAC 32. Registrar's Signeture June Buildson-Randelle

ogen 25 completed cause of death (Item 23e) (Type, Print)

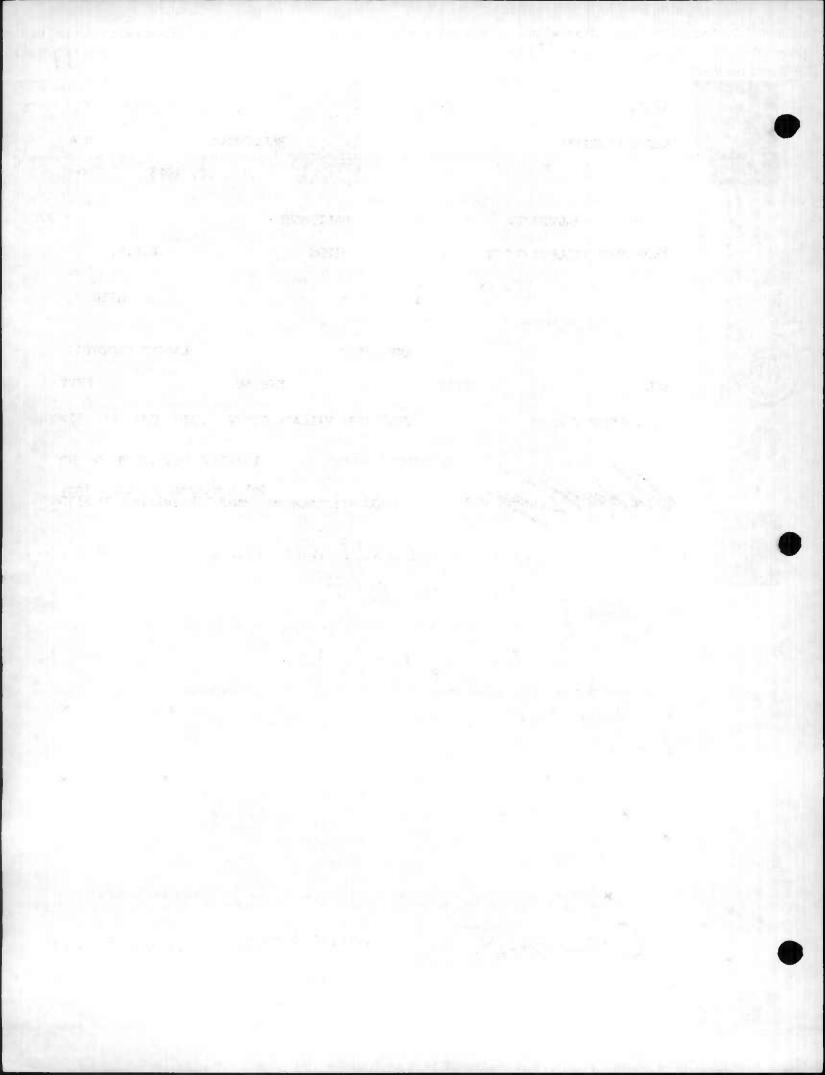
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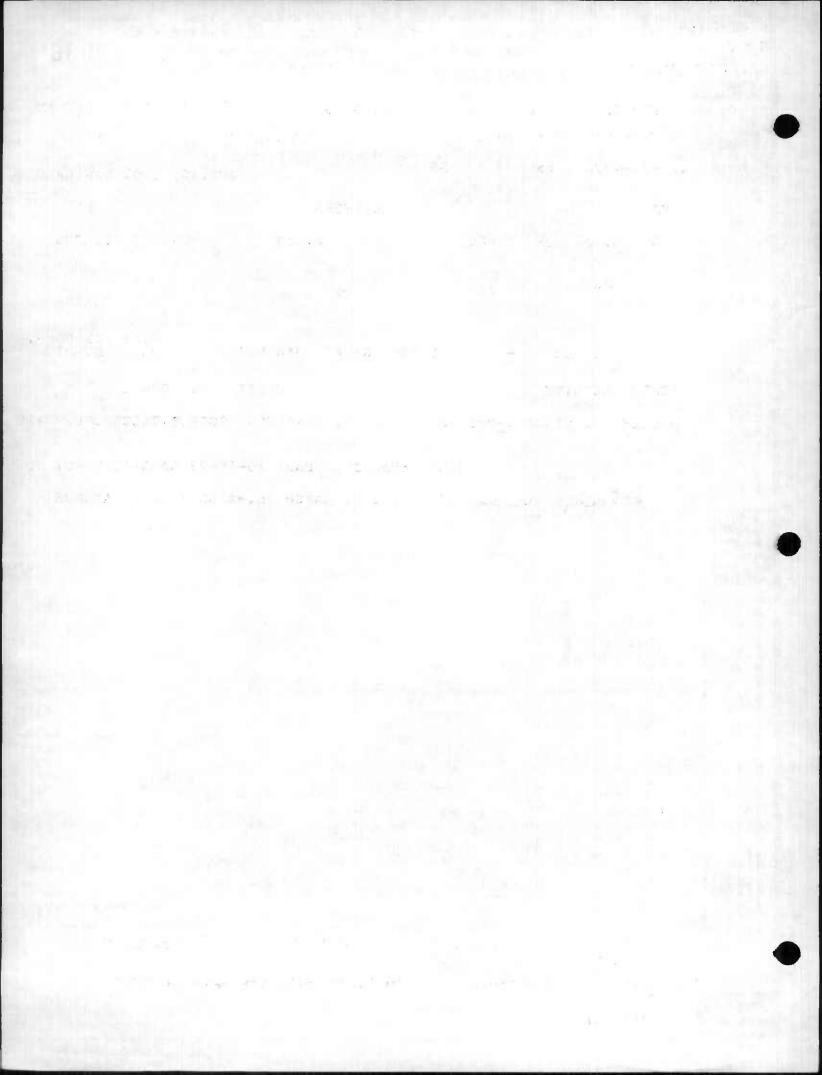
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State of Maryland / Department of Health and Mental Hygiene

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	Director		215-70-4770 Usual Residance of Decedent	<b>1/1</b> /M 2□ F	36	Yrs. Mor	nths Days	Hours Min.	8. Date of Bin (Month, De JUN •	10, 196	51 M	eca (Stete or Foreign ry) ARYLAND			
	death with the Maryland ma 23a or 28a-f show	Director		a	10c. City, T	own or Location						od. Inside City Limits			
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5-0020	ai', or its	by Funeral	11. Marital Status  1 Navar Married And Ma	12. Was Decedant Armed Forces  1  Yes X M If Yes, Give Year or Datas:	7	If Yes,	specify Cuba	dispanto Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		- Amarice k, White, e				
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lan	should be nd Mental marked o	To Be	JERRY GIDDI							. MORGA					
Maryland	2 she end end is m		19e. Informant's Name/Relationsh		1		dress (Street	end Number or Ru	ıral Route Numbe	er, City or Town,	Stete, Zip				
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Baltimore,	permit. Peges 1 and Department of Health Important: If Item 27 any injury or other tr		1 X Kurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signeture of Funerel Servica L	ecify) Icansee	KING	WM .	RIAL ne and Addre	PARK I	ı. <b>-</b> 4300	WABASI	cation - City or Town, State				
	Physician /Medical Examiner	100	23a. Part1. Enter the disease, or shock, or heart failure. List of the control of	nly one cause on each li	OTIC INT	OXICATIO	N	ng, such as cardiad	or respiretory ea	rrest,		Approximate Interval Between Onset and Death			
	be de la sit	Examiner		b.	Due to (or as	o consequence	2 01).								
60,	be executed ician end buriel-trensit	<b>65</b> 1	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	C	Due to (or es	a consequence	of):								
Box 687	death certificate t e attending physic of for use as the b	n/Medica	thet initieted events resulting In death) Last	d	Dua to (or as	a consequence	of):								
O. B	0 0 %	Physician/M	Pert II. Other significant condition	ns contributing to death b	out not resultin	g in the underly	Ing ceuse giv	ren in Pert I.	23b. Dld 1	tobacco use con	tribute to	tha cause of death?			
n.	requires thet the de seen signed by the a hould be deteched t	by Ph							10	Yes 2 No	3 Prob	ably 4 Unknown			
Records,	aw requii ss been s 2 should	Completed							24e. Was perfo	en eutopsy rmed?	con	re eutopsy findings ilable prior to apletion of cause eath?			
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Division of	ding Ph h. After thi funerai	on: T	27. Manner of Death 1 □ Naturel 5 □ Pending	28a. Dete of Inju		b. Time of A	28c. Injur Wor			now injury occurre					
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≥ O	の共言に	O	4 ☐ Homicide determin	found in	c. (Specify) motel				City or Tov	d.	rt In	n, Baltimore			
	To the Hospital within 24 hours e To the Funeral Completely filled	edical		Physician: To the best xaminer: On the basis o and menner st	t exeminetion	end/or investige	rred at the tine	ne, date and pleca pinlon, death occu	red et the time,	ceuse(s) end mar dete end plece, a	nner es sta ind due to	ited. the cause(s)			
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)			Alysts	A VVo	roly	MP	0.0	C.M.E		OCT. 1	2, 19	97			
			30. Name and address of person w	ho completed cause of a			treet	Baltimo	re. Mars	zland 21	201				
	Sta	te	31. Date tiled (Month, Day, Yeer)	Suha Dands	ar's Signature	00.		TALL CHIN	LC, HOL	TURE 21.	201				
	Registr	ar	OCT 1 4 1997	gruna Davids	on-Nation										



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death Month Herber John 23:36 October 1997 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hopkins Hospital Baltino Ne If Under 24 Hrs. 8. Date of B Johns 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foraign Country) 10M 20F Months Days Hours Min 492-84-6657 20 HaWAII Usuai Residenca of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Ball more 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21230 2602 AUE USA Patapsco 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Biack, Whita, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Naver Marriad 2 Married 1□ Yes 21 No Black 3 ☐ Widowed 4 ☐ Divorced 15. Dacedant's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b, Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Supervisor 10th grade Supervisor 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) GIVERS, Sr. Reed John Patricia 19a. Informant's Neme/Raiationship (Type, Print) 19b. Mailing Address (Straat end Number or Rural Route Number, City or Town, Stete, Zip Code) AUL, Patricia Patapsco Batton MD GIVERS 2602 W. 20b. Plece of Disposition (Nema of cemetary, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriei 2 □ Cramation 3 □ Removal from Stata 10-15-97 Charles CEM St. Louis 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Service Licensee 22. Name end Addrass of Facility North AUR F. 4 EAST 23a. Part1. Enter the disaasa, or compshock, or heart failure. List on cations that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, na cause on each line. Approximate Interval Between Onsat and Death Immediata Ceusa (Final Sepsis disease or condition rasulting in death) 945 tonsi bscess low 0 Sequentially iist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): mmuno suppression Due to (or as a consequence of): Kem, a ogenou Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 TYAS 2 No 25. Was case rafarred to medical axaminer? 26. Placa of Death (Check only one) 1 Yas 25 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 27. Manner of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Naturai 1 Yes 2 Accident 3 Suicide 6 Could not be datermined 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 T Homicide

Physician: The law requires that the death certificete be executed P.O. Box 68760. of Vital Records, certificate Division Attending death. after death Oirector in th

Examiner Physician/Medical Be Completed by

**Physician** 

/Medicai

**Examiner** 

**Funeral** 

Director

"natural", or items 23s or 28s-f showed call Examiner man be notified at

marked other than

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Department Information Informa

Physician /Medical

Examiner

Hygiene.

Pages 1 end 2 should be nent of Health end Mentel

Completed by Funeral Director

Be

filed within 72 hours efter death with the Maryland

21215-0020

Baltimore, Maryland

Medicai Certification: To

State

Registrar

Blankson MD

29b. Signature and tiffa of ceftifier

29a. Certifier (Check only one)

Medicine Resident 30. Nama end address of person who complated causa of death (Item 23a) (Type, Print) Tower building 600 110

29c. License numbar

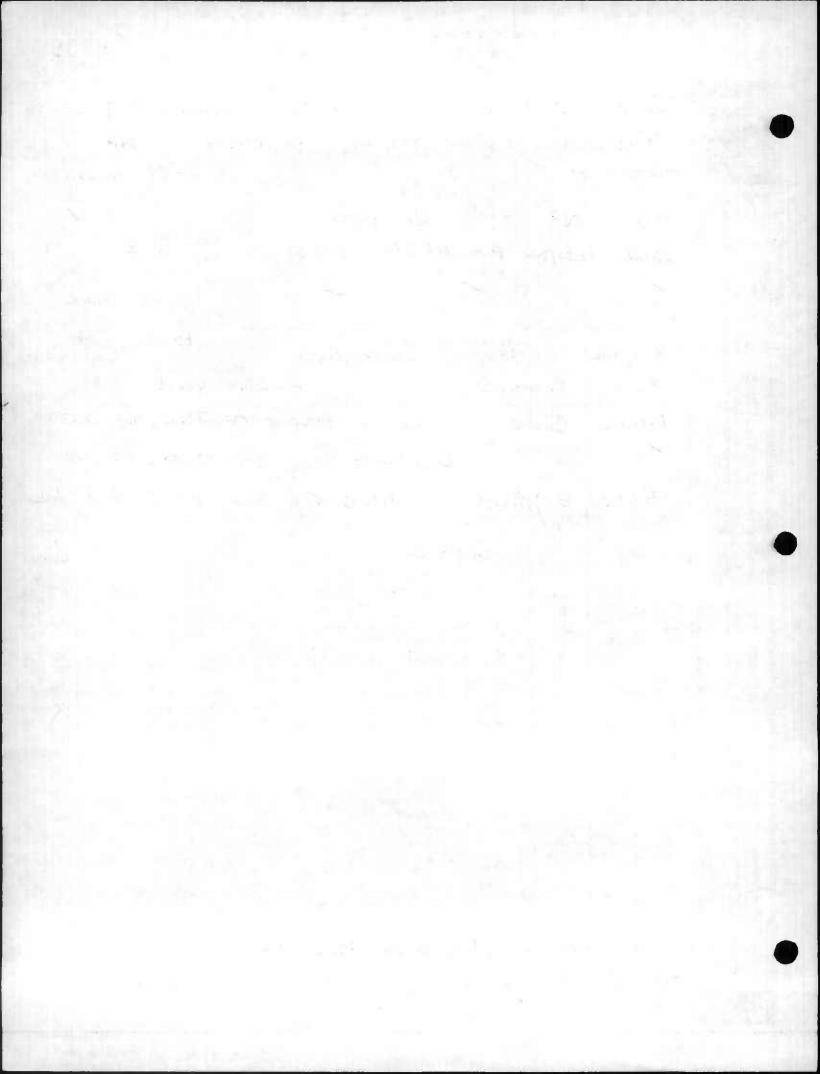
Certifying Physician: To the best of my knowledge, death occurred et tha tima, data and place, and due to tha cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the tima, data end place, and dua to tha causa(s) and manner statad. 29d. Date signed (Month, Dey, Yeer)

North Volfe St Baltimore MD 21287

31. Day (eq (Month, Day, Year) 14 1997

32. Registrar's Signature The Davidson-Randell



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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JEBURAH	DIANE	CCON	HEDGEPETH

		ROSS HEDGEPETH rt I,27 per MEO G-753 1. Decedent's Name (First, Middle, I				tificate o		2. Date of I	Reg. No.		Tima of Death
Physicia: /Medica Examine	al	Deborah Dia 4a. Facility Nama (If not institution, g JOHNS HOPKIN	ive street and number)		epetl	1	4b. City, Town,	or Location of De	ath 4c. Count	Yaar 1997 ty of Death	4:18pm
Funeral Director			Sex 7. Ag	a (In yrs. Ias	t birthday) Yrs.	If Under 1 Ye Months Day	ar If Undar 24 I	frs. 8. Data of 8		9. Birthplaca Country)	(State or Foreign
ahow	o.	Usual Rasidance of Dacedant  10a. Stata 10b. County  Md • NA			Town or Loc						nsida City Limits
th with the Maryle 23a or 28a-f shor	Director	10a. Street and Number				10f. Zip Code	a		10g. Citizan of	What Country?	
urs after dea al', or Items Kominer m	by Funeral	4104 Raymonn  11. Marital Status  1 Naver Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedant Armed Forcas?	Evar In U,S.		2121 Vas Decedant of Yas, specify C	of Hispenic Origin? uban, Maxican, Po	(Specify Yes or larto Rican, etc.)	USA No- 14. Re Bli Speci	ice - Amarican Ir ack, Whita, atc.	
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s 1 end 2 should be f Health and Menta tem 27 is marked other traumatic av		19a. Informant's Name/Ralationship Mary Rich					eet and Number of				
permit. Tages I end a long to be perment of Health a limportant: If hem any injury or other tra gence.	1	20a. Mathod of Disposition  1x Burlal 2 Cremation 3  4 Donation 5 Other (Special	☐Ramoval from State	20b. Plac	e of Dispos	ition (Nama of atory or other)		Data	20c. Location	- City or Town,	Stata Md.
Physician /Medical Examiner		23e. Part Brian to disease or construction of the construction of		AC ARRH	Do not anta	r tha moda of o	rch FH dying, such as care			App	oroximata rval Batween sat and Death
or bur	N/Medical Examiner	Sequantially list conditions, if any, laading to immediata causa. Entar Undarfying Causa (Disaasa or Injury that initiated avants rasulting in daath) Lest	c	Dua to (or a							
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this certificate has all director, page 2		25. Was casa rafarrad to madical							Yas 2□No	1 XYa	s 2□ No
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leath. for: After the fune	Certification:	27. Mannar of Death  1  Natural  2  Accident  3  Suicide  4  Homicida	ba on Disease their	ļ	Bb. Tima of Injury a, farm, stra	M 1	njuryat Vork? □ Yas 2 □ No	28d. Dascrib	(Street and Nun Fown, State)	urred	ute Number,
n 24 hound Plately fill	regical		hyaician: To the best of iminer: On the basis of and marner sta	axamination		astigation, In m			a, data and place		causa(s)

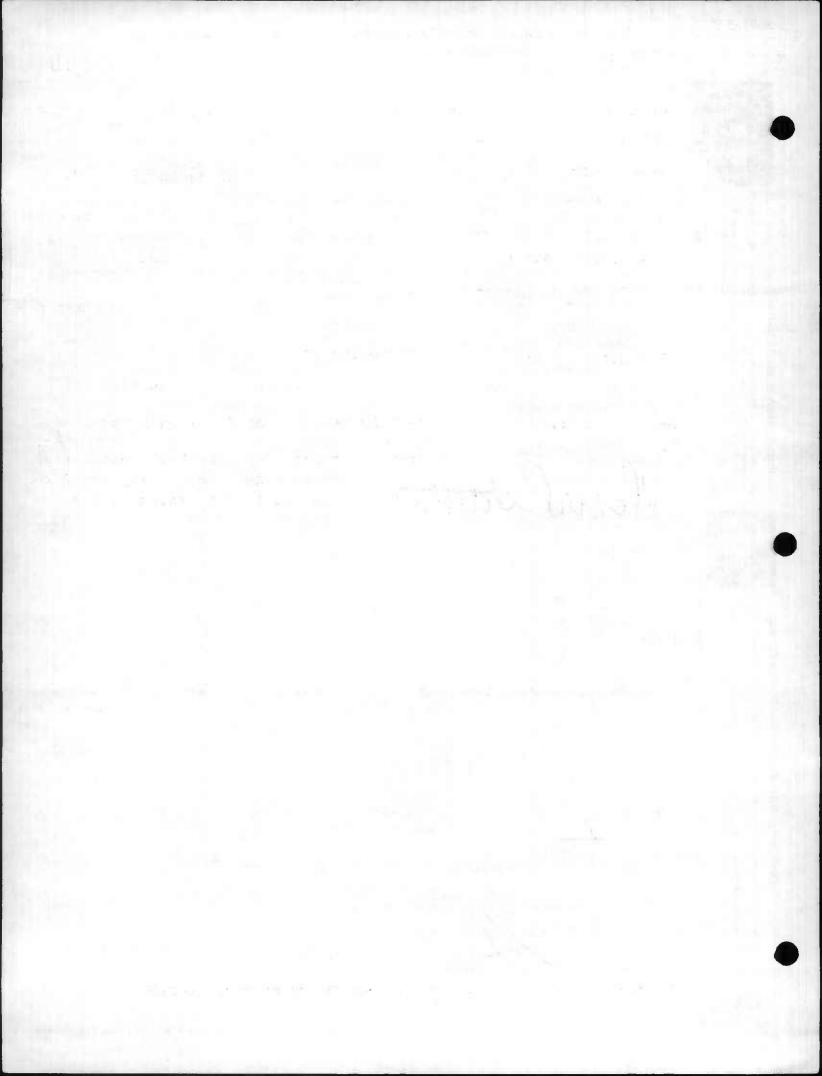
State Registrar 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

DAVID FOWLER M.D. 31. Data filed Don't Day Year 1997

Penn Street, Baltimore, Maryland 21201

O.C.M.E.

OCTOBER 9, 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle Last) 2. Data of Deeth 3. Tima of Death **Physician** /Medical 4a. Facility Name (If not institution, giva street and number, or Location of Daath 4b. Clty, Town, 4c. County of Daath Examiner 105p17 NIA CL 0 If Undar If Undar 1 Yaar Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** 10 M 20 F Days 216 - 30 - 6917 Usuai Residence of Dacadant Yrs. Director the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be nothed at 1 Yas 2 No Director BALTIMORE MD NA 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6 21217 "natural", or items 23a NORTH MOUNT STREET Funeral USA 12. Was Dacedant Evar In U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Was Dacedant of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours efter nent of Health end Mentel Hygiene. 1 Nevar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: BLACK Specify by 3 □ Widowad 4 □ Divorced Yaar or Datas: Completed 15. Dacedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry nd Mentel Hygiene. marked other than Eiementary/Sacondery (0-12) College (1-4or 5+) 10 TH GRADE TACTORY NIA 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be MINES EDNA traumetic LOUDER 19a. informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) permit. Peges 1 end 2 s Department of Health er Important: if Item 27 is any Injury or other trau .00 BALTO. EUJAH HARRIS HUSBAND N. MD 21217 IYJOUNT 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramovai from Stata 10/15/97 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) GARRISON TOREST VAUGHN C. GREENE FUNERAL SERVICE 21. Signatora of Funaral Sarvice Licensee 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervei Between Onsat and Death **Physician** lenocarcinemo /Medical Immediata Causa (Finei disaesa or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to Immadiata cause. Entar Undarlying Causa (Disaasa or Injury that Initiated evants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical the Dua to (or as a consequence of): for use es is certificate has been signed by the a director, page 2 should be deteched to Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? Yee 2□ No 3□ Probably 4□ Unknown Records, þ Completed 24b. Wara autopsy findings availebla prior to compiation of ceusa of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No Division of Vital or Attending Physician: 25. Was cesa refarred to medical exeminar? Be 28. Piace of Deeth (Check only one) P 1 Yas 2 PNo Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA After this filled in by the funerel 27. Manner of Death
Natural
2 Accidant Certification: 28a. Deta of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. injury at Work? 5 Panding Invastigation s efter deeth. 1 Yas 2 No 3 Suicida 6 Could not be datarminad 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homloide To the Hospital within 24 hours e Medicai 29a Cartifian Dertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and after of certifie 29d. Data signed (Month, Day, Year) death (tem 23a) (Type, Print)

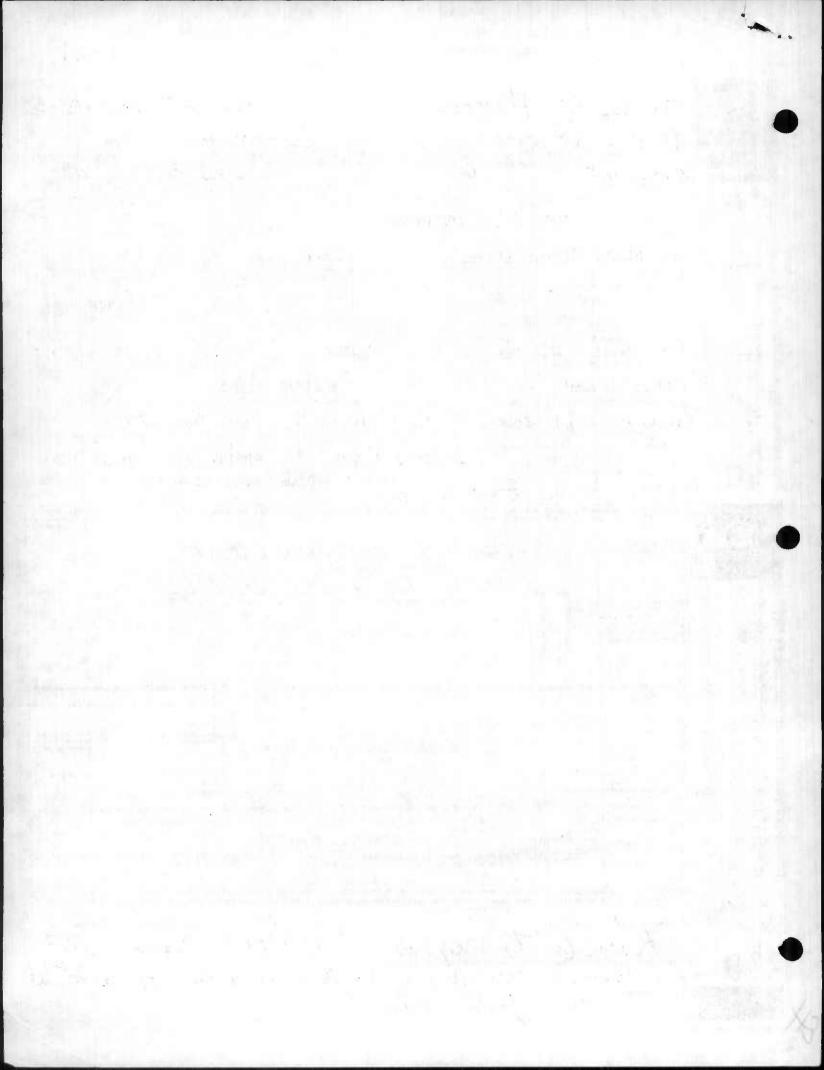
Registrar

State

1997

Registrar's Signatura

DHMH 16 Rev 6/95

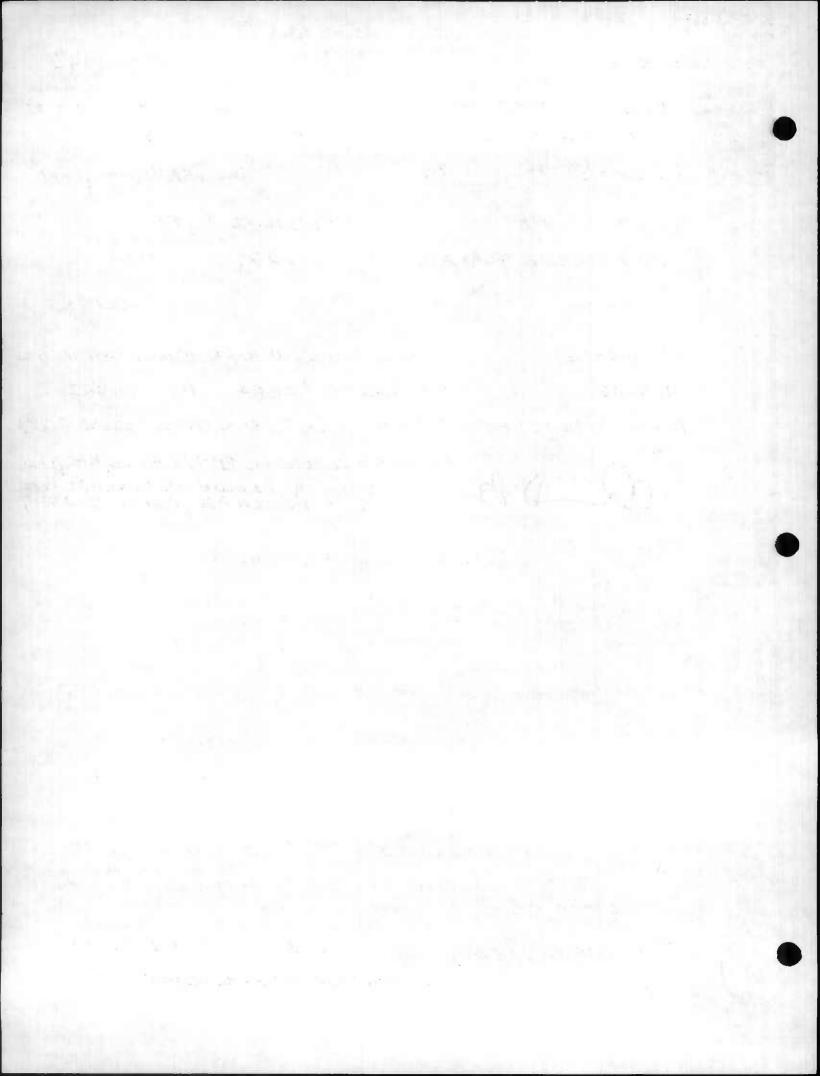


DHMH 16 Rev 6/95

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7 2001. 2

MINITIONI	LAI	MONT HOLLAND		Certific	ate of Death	B	eg. No.	30042	
		Decedent's Name (First, Middle, Last)		THE VALUE OF	190199 111	2. Dete of Death 3. Tima of Deeth		3. Tima of Deeth	
Physic /Medi		ANTHONY L	.AMONT	HOLLAND		OCT.	10, 199	7 0630 AM	
Exami		4a. Facility Name (If not institution, give street end number)  4b. City, To				or Location of Death MORE  4c. County of Death N/A			
Funeral Director		5. Sociel Security Number 6. Sex 19-96-9934 100 M 2 F 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Months Days Hours Number 19-96-9934 Hours Number 19-96-96-9934 Hours Number 19-96-9934 Hours Number 19-96-9934 Hours Number 19-96-96-9934 Hours Number 19-96-96-9934 Hours Number 19-96-96-9934 Hours Number 19-96-96-96-96-96-96-96-96-96-96-96-96-96			Hrs. 8. Date of Birth (Month, Dey, Year) DEC, 05,1971 MARYLAND				
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f show any highty or other traumatic event, in Westerl Exercise.		10a. Stata 10b. County 10c. City, Town or Location					10d. Inside City Limits		
	ctor	MARYLAND N	14		BALTIMO	RE CI	TY	1 No Yes 2 No	
	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country?							
	era	4303 ADELL					5A.		
	by Funeral	11. Maritel Status  1. Navar Marriad 2 Married  3 Widowad 4 Divorced	<ul> <li>12. Was Dacadent Ever in U Armed Forces?</li> <li>1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates:</li> </ul>		cedent of Hispanic Origin? (specify Cuban, Mexican, Puas 2200 Specify:	rto Rican, etc.)		- Americen Indian, k, White, etc.	
	eted	15. Decedent's Educ (Specify only highest grade	cation	16e. Decedent's U	Isuai Occupation	ndring	16b. Kind of Bus	siness/Industry	
	Completed	Elementery/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)							
	00	12 THGRADE WARE HOUSE WORKER ADVANCE HARKETING 17. Fether's Name (First, Middle, Maiden Surname)							
	To Be	MONROE  19a. Informent's Name/Reletionship (Ty)		OLLAND 19h Maijing Addr	DEBI	RA f	4,	MOORE	
		19a. Informent's Name/Reletionship (Type, Print)  19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)  DEBRA A. MOORE (MOTHER) 4303 ADELLE TERRACE APT. 302, BALTO. HD. 21229							
		20a. Method of Disposition							
	1 9	1 Beurial 2 Cremetion 3 Removal from Steta 4 Donation Content (Specify)  ARBUTUS CEMETERY 10-16-97 ARBUTUS, MARYLAND							
Balting permit. Pa Departmen Important: any injury		21. Signature of Furient Service Licenses & TOSEPH H. BROWN JR. FUNERAL Home 2140 N. FULTON AVE. BALTO, Mp. 21217							
-	F	23a. Pert1. Entar the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failura. List only one cause on aach line.  Immediate Cause (Final disease or condition resulting in deeth)  Due to (or es e consequence of):							
Physician /Medical Examiner									
cate be executed physician and sthe bunal-transit	Examiner	Ceuse (Disease or Injury that Initiated events resulting in death) Last  Due to (or as a consequence of):							
	Exar								
ficate be ex physician is the burial	edical								
ISION Of VITAL HECOIDS, P.O. BOX ( the ding Physician: The law requires that the death certificate death. tor: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use a	2								
	Physician/								
	nyslo	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.						tribute to the causa of death?	
	by Pl					1 L Ye	es 2M No	3 Probably 4 Unknown	
	Completed t					24a. Was ar		24b. Were autopsy findings available prior to completion of ceuse of deeth?	
	omo					1.21.Ye	s 2 No	1ÆYes 2□ No	
	Be C	25. Was cese referred to medical examiner?			26. Piace of De	eth (Check only on	е)		
	To	XX Yes 2□ No				Home 5 ☐ Residence 6 ☐ Other (Specify)			
	ion:	27. Manner of Death  1 Neturel 5 Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of injury	28c. Injury at Work?	28d. Describe how injury occurred			
	Certification:	2 Accident Investigation 3 Suicide 6 Could not be				281. Location (Street and Number or Rural Route Number, City or Town, Stete) 2400 N, Dukeland			
al or A	ert	4 AHomicide determined				City or Town, Store) 2400 N. Dukeland Baltimore City, Maryland			
In Hospital	edical (	29a. Certifier  (Check only Wedical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner es stated.							
To the Hos minin 24 hd To the Fun	Medi	one) XX	and manner statad.						
010	-	29b. Signature and title of certifier  29c. Licansa number				29d. Dete signed (Month, Dey, Year)			
112		30. Nama and eddress of person who completed cause of death (Item 23e) (Type, Print)							
JA)			mpleted cause of death (Item dentz, MD		Street, Balti	imore, Mai	ryland 2	21201	
1	ite	31. Date filed (Month, Day, Yeer)	32. Registrar's Signo						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey **Physician** ctober /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Jawn, or Location of Deeth Examiner 19 Juson enter leled 1 7. Age (In yrs. lest birthdey) If Under 1 Year 5. Sociel Security Number 9. Birthplece (State or Foreign Country) **Funerai** Deys Months Director 213-36-8120 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits Balto 1 ☐ Yes 2 No Ma ather ville 28a-f 10e. Street end Number 10g. Citizen of Whet Country? Avenue Iroad **Нетя** 23а 21093 Funeral 12. Wes Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 1□ Yes 2 No "natural", or by 3 Widowed 4 □ Divorced Completed the Medical 16a. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry markad other than College (1-4or 5+) Hygiene. chgrade NA Baltimore, Maryland 17. Father's Name (First, Middle, Lest) Department of Health and Mental I Important: If Itam 27 is marked of any Injury or other traumatic eve larence Johnson 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Blud 410 - Daughter 6201 hoch Ranen Da Ho Md 21239 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from State Valley 4 ☐ Donetion 5 ☐ Other (Specify) Timonium, 21. Signature of Funeral Service Licensee 4300 Da Ho Md 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. **Physician** Immediete Ceuse (Finel one week diseese or condition resulting in deeth) Examiner Due to (or es e consequenca of): Examiner and i-transit be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting In death) Last Due to (or es e consequenca of): Physician/Medical Due to (or es e consequenca of): Box ( Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 0 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Demectr Records, by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 XNo Vital or Attanding Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospice Certification: To Division of funeral 27. Menner of Deeth 1 Neturel 28c. Injury et Work? 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Yes 2 No death. 2 Accident investigation hours efter death 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end menner steted. 29a. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture end, title of cartifier 29c. License number October 9, 1997

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Registrar

**DHMH 16 Rev 6/95** 

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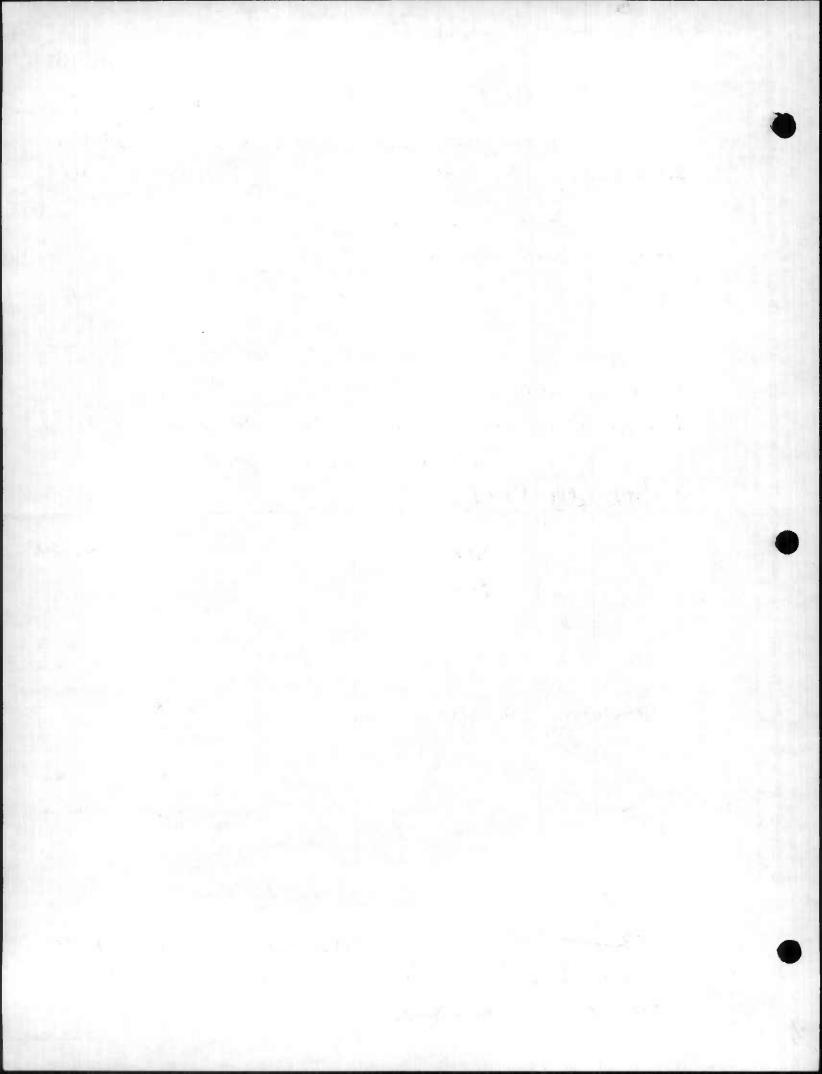
State

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signeture

Kenneh M. Green, no

31. Date filed (Month, Dey, Yeer)

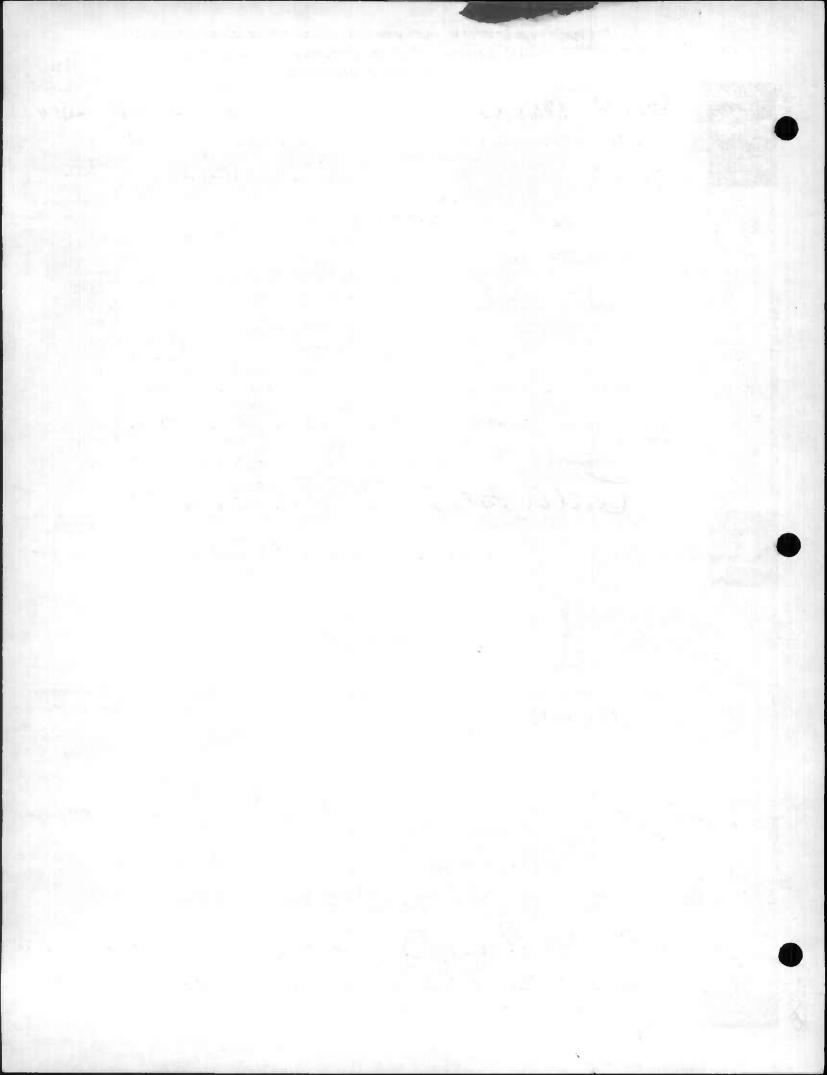


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month HAWKINS 10 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPICE RICHEY **JOSEPH** N/A BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6 Sex Birthplece (State or Foreign Country)
 MD . 7. Age (In yrs. last birthday) **Funeral** 1□ M 2# F Days 216 20 8749 84 Yrs. Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is merked other than "naturel", or items 23a or 28s-f show any Injury or other traumatic event, the Maryland Emerican 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits #□ Yes 2□ No Director MD. CATONSVILLE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6309 CRAIGMONT ROAD 21228 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes #☐ No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, at AFRO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes # No Specify: Specify: AMERICAN by 3 ∰ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry STANLEY HOME College (1-4or 5+) Elementery/Secondary (0-12) PERSON **PRODUCTS** 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be **JOSEPH** A. WILLIAMS MARY Ρ. IRELAND 10 19e. fnforment's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY SCRIBNER 6309 CRAIGMONT RD. CATONSVILLE. MD. 21228 DAUGHTER 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1曲 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) ARBUTUS MEM. PARK 10/18/97 ARBUTUS, MD. 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A.

1000 FUTABLE DE RALTO, MD. 21217 21. Signeture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the down. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Cerebral Vascular Thrombosis Immediate Ceuse (Final disease or condition resulting In death) /Medical minutes. Examiner Examiner attending physician end for use es the buriel-transit thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai Due to (or as a consequenca of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown ASCV Division of Vital Records, by Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? this certificate hes 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funerel Director: After this certifica 25. Was case referred to medical exeminer? funerel director Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Ho \$ (CQ. 70 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Phyafcfan: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated. Medicai 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifing 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 828 N. Eutawst. 15g/to, Md. 2120/ - revisor Mi July 32 Hegistrer's Stanature le 31. Date filed (Month, Day, Year) State 141997 OCT Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death **Physician** Samuel Edward Hopkins 1997 OCT 11:15 pm /Medical 4a. Fecility Nema (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year Months Days If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Birthplece (State or Foreign Country) **Funeral** Yrs 219-01-0607 78 Director Maryland Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at MD Anne Arundel Annapolis X Yes 2 No Director 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? with 1199 Southview Road 21401 USA 2 should be filed within 72 hours after death is and Mental Hygiene.
Is marked other than "natural", or items 23. Funeral 12. Was Decedent Ever in U,S. Agmed Forcas?

1 Nays 2 Now WW II Was Dacedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Reca - Amarican Indien, Bleck, White, etc. 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 No White f Yes, Give Yeer or Dates: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest greda completed) 16b. Kind of Business/industry Elementary/Secondery (0-12) College (1-4or 5+) Machinist Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Melden Sumeme) Milton Owen Hopkins Bertha Margaret Fawcett 19e. informent's Neme/Reletionship (Type, Print) 19b. Meliing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If New 27 Is Virginia S. Hopkins/wife 1199 Southview Dr. Annapolis, MD 21401 20e. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Steta 20b. Piece of Disposition (Neme of cematery, cremetory or other piece) Dete 20c. Location - City or Town, Stata injury or Metro Crematory, Inc. 10/13/97 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funaral Service License eny in <sup>22</sup> Name and Address of Feeling Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 Edward A. Gregorchik 299 Frederick Rd. Baltimore 23e. Parti. Enter the diseasa, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or haert failure. List only one cause on each line. Approximete Interval Batween Onset and Deeth **Physician** /Medical tmmediate Ceuse (Finel disaesa or condition resulting In death) Examiner Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Undarfying Ceuse (Disease or injury that initiated events resulting in death) Lest pur burnal physician the buria Physician/Medical Due to (or es a consequance of) 1 990 ò signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Dtd tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown þ 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? Completed peen has 1 Yes 2 KNo 1 ☐ Yes 2 ☐ No certificate 25. Wes case rafarrad to medical examiner? Be 26. Piece of Death (Check only one) Hospitei: Other: 4□ Nursing Homa 5□ Rasidance 6 □Other (Specify) To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 岩 28e. Dete of tnjury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28c. injury et Work? 28d. Dascribe how injury occurred Certification: 1 Netural 5 Pending invastigation 1 Yas 2 No 2 Accident I or Attend after deat Director: 6 Could not be determined 3 Suicide 28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one) Cartifying Physicten: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

[2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner steted. Medical 29c. Licensa number 29b. Signature 29d. Date signed (Month, Dey, Year)

of death (item 23a) (Type, Print)

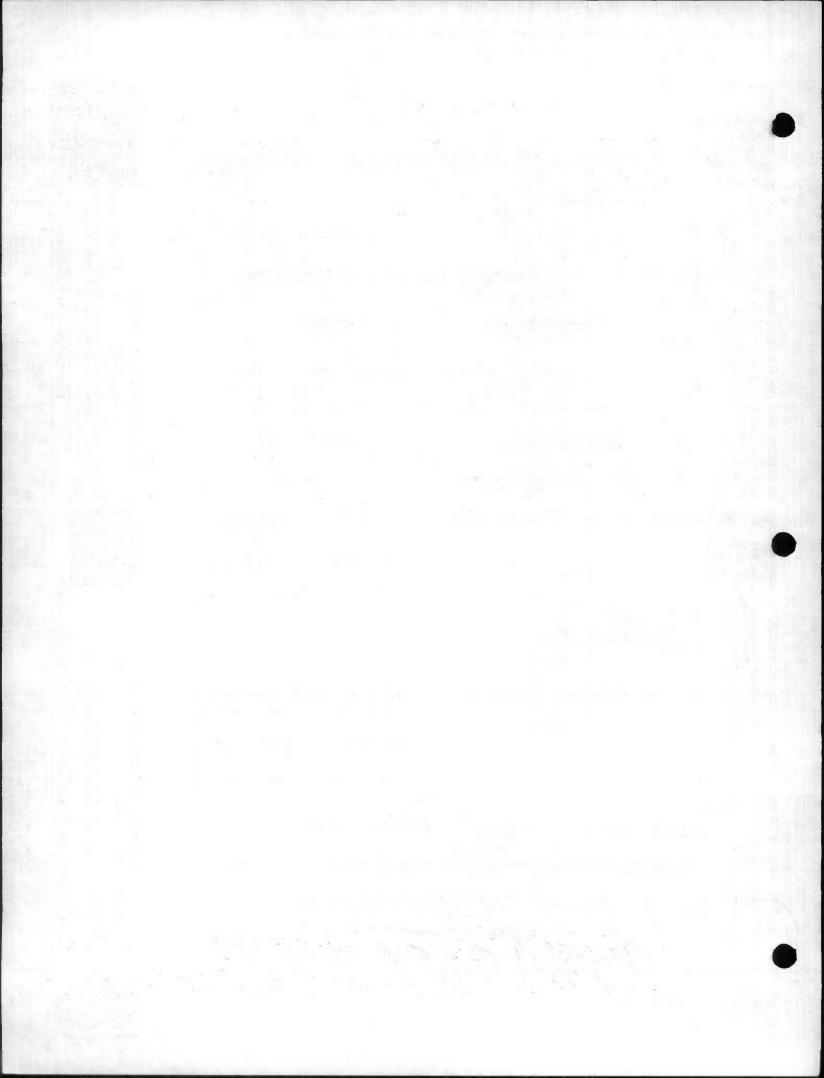
32. Registrer's Signeture

Wia Davidson

State Registrar (Month, Dey, Year)

1997

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day William Edmund Hurst, Sr. October 11, 1997 8:12m 4e. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 600 Saber Lane Arnold Anne-Arundel If Under 1 Year If Under 24 Hrs. Hours Min. Birthplaca (State or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months Days Hours 15₹M 2□ F 223-30-1792 Yrs July 05, 1931 TX 66 Usuet Residence of Dacedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne-Arundel Arnold Maryland 1 ☐ Yes TNO 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 600 Saber Lane 21012 United States 12. Was Decedant Ever in U.S. Armed Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, atc. 11. Maritel Status Armed Forces?

1 Xi Yes 2 No Air Force
If Yas, Giva
Yaar or Datas: Korean War 1 Navar Marriad 2 Married 1 ☐ Yes 2XXNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Coilega (1-4or 5+) Diplomatic Duty Free Corp. Executive Sales

7 is marked other than "natural", or items 23s or 28s-f show trsumstic event, the Modical Examinar must be notified at 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiena. Pm 27 is marked other than "natural", or flems 23: Completed 15. Decedant's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) 12 2+ 17. Fether's Name (First, Middla, Last) Henry G. Hurst 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is any injury or other trau sncs. Alfredda J. Smith/Hurst/Wife 600 Saber Lane, Arnold, Maryland Saltimore. 20b. Piece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition ₩Burlel 2 Cremetion 3 Ramovai from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) Obstruting Examiner Dua to (or as a consequence of): Examiner physician and s the burisi-trans Sequantially list conditions, if any, leading to immedieta causa. Entar Underlying Cause (Disaase or Injury that initiated events Dua to (or as a consequence of): certificate be exe Box 68760 Physician/Medical that initiated avents resulting in death) Last Due to (or es e consequance of): 88 9SN for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. e u signed by Hodeling disease Division of Vital Records. þ 8 Completed has page 2 director, 25. Was casa rafarred to medical axaminar? Be Other: 4 Nursing Home 1 Yas 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this Iuneral 27. Manner of Death 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: Naturai 5 Panding 1 ☐ Yas 2 ☐ No invastigation or Attend after death Director: / 2 Accident the 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 ☐ HomicIda Hospital To the Hospital within 24 hours a To the Funeral C edical completely (Check only one) 29b. Signeture end title of certifier 29c. Licensa number

20c. Location - City or Town, State Cedar Hill Cemetery October 15, 1997 Baltimore Maryland P. Doda, Jr22 Nama and Address of Fecility
Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore, Maryland 21230 Approximeta Interval Batween Onset and Death Relmonn DISENX 8 314

24a. Was an autopsy performed?

18. Mothar'a Nama (First, Middla, Maidan Sumama)

Lena Sweeney

1 Yas 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only one) 5 Residence 8 Other (Specify) 28d. Dascribe how Injury occurred

23b. Did tobacco use contributa to the cause of death?

12 Yee 2 No 3 Probably 4 Unknown

24b. Ware eutopsy findings available prior to completion of cause of death?

281. Location (Street and Number or Rural Route Number, City or Town, Steta) Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated.

29d. Data signed (Month, Dey, Year)

D40854

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

301 St Paul PI Trop uscher

Julia Francis Dandall

Bultmare

State Registrar

**Physician** 

/Medical

Examiner

10e. Steta

Direct

Funeral

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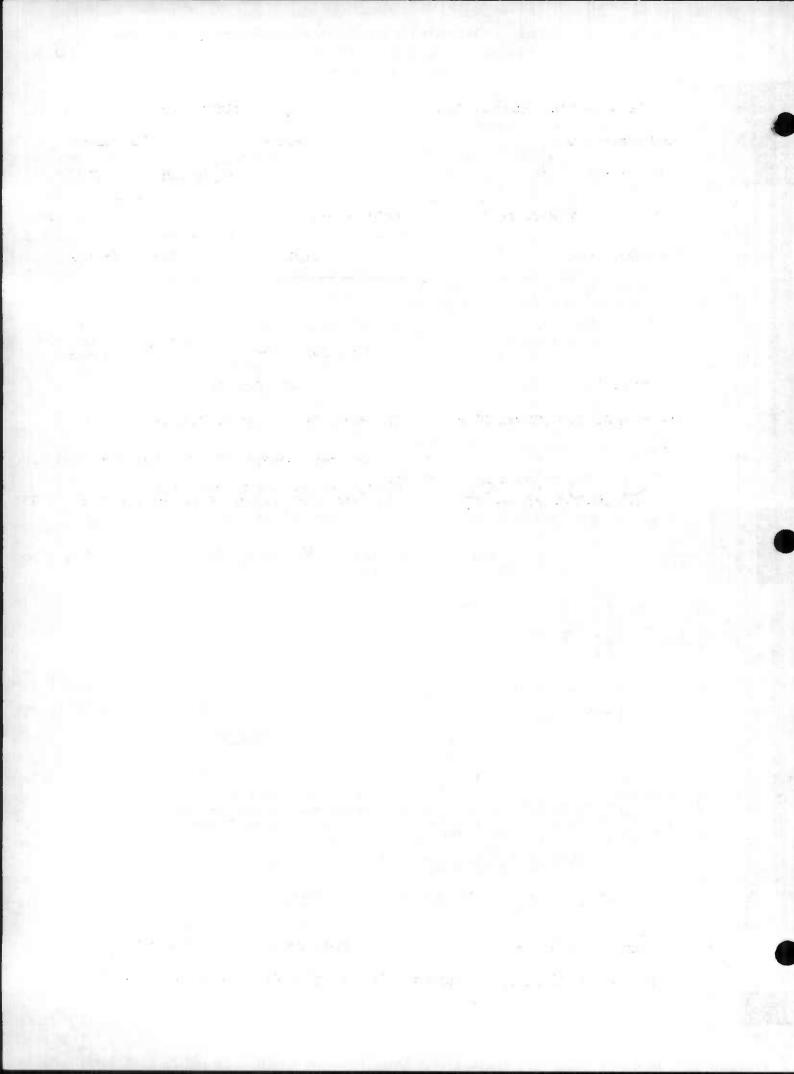
MD

**Funeral** 

**Director** 

with the Maryland





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last)
CHRISTOPHER JOHN HUGHES, JR. 2. Date of Death 3. Time of Death OCTOBER 14, 1997 **Physician** 6:20 A.M. /Medical 4b City Iown or Location of Deeth MILLERSVILLE 40 KNOLLWOOD MANOR NURSING HOME 4c. County of Death Examiner ANNE ARUNDEL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min, 6. Sex M 2□ F 5. Sociel Security Number 8. Date of Birth 5/24/1916 9. Birthplece (State or Foreign **Funeral** 218-10-9556 Yrs. MARYTAND **Director** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinat must be notified at MD ANNE ARUNDEL MILLERSVILLE 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 899 CECIL AVENUE 21108 U.S.A. 12. Was Decedent Ever In U,S. Amed Forces? 1 M Yes 2 □ No If Yes, Give WWII Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XX o Specify: Specify: WHTTE P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALES CLERK GROCERY STORE Department of Health and Mental Hygis Important: If Itam 27 is marked other tank Injury or other traument. 17. Father's Name (First, Middle, Last)
CHRISTOPHER JOHN HUGHES 18. Mother's Name (First, Middle, Maiden Surname)

MARY LOREK 19a. Informant's Neme/Relationship (Type, Print)
SYLVIA M. KACKLE - FRIEND 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 135 N. MEADOW DR., GLEN BURNIE, MD 21061 20a. Method of Disposition

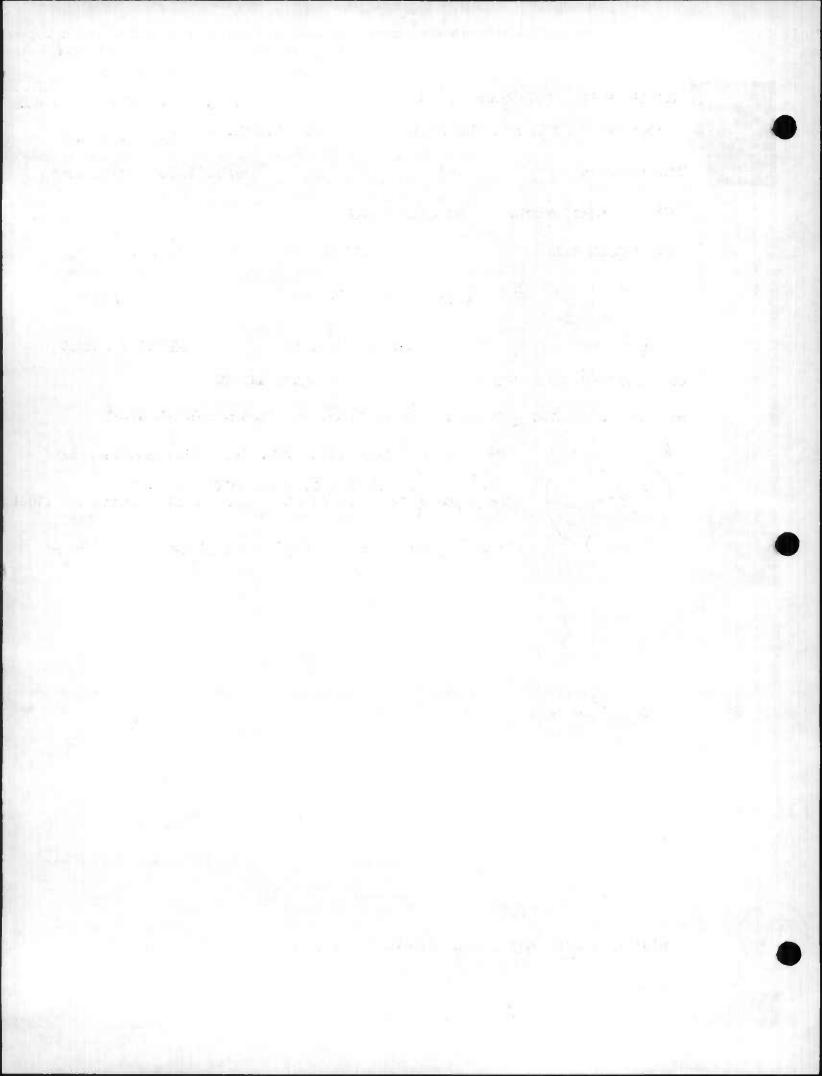
XXBurial 2 □ Cremetion 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State CROWNSVILLE VET. CEM. 10/7 CROWNSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Fecility
RAYMOND C. FINK FUNERAL HOME 23a. Part1. Enter the disease, or co shock, or heart failure. Lis on 426 CRAIN HWY, SW., GLEN BURNIE, MD 21061 pliceflors that ceused the death one of the mode of dylng, such as cerdiac or respiratory errest, one cause on each line. Approximete interval Between Onset end Death Physician Acute Cerebovoscular Acadent /Medicai Immediate Cause (Finai disease or condition resulting in death) Examiner Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or as e consequence of) Box 68760, Physician/Medicai Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? evelovos cular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitai: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Netural death. 1 Yes 2 No 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) aftar 4 Homicide Nours Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 21684 10.4.87 Whymeen Attending Doctor 30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print) CONT PASADENA, MD 21122 CN.CYRIAC.M.D 8109 RITCHUZ 31. Date filed (Month, Day, Year) State

Registrar

1 4 1997

32. Registrar's Signature July Davidson-Randell



State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month DOROTHY HECKATHORNE LOUISE 2:03 24 October 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL BALTIMORE N/A Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 M XX 281-03-6327 Yrs. Director 81 02-20-1916 OHIO Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at MD. N/A BALTIMORE CITY Director X1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 830 WEST 40th. STREET 21211 U.S.A. Items 23a Funeral 12. Was Decedent Ever In U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 72 hours after XXNever Married 2 Married 1 ☐ Yes XXNo If Yes, Give Year or Dates: Maryland 21215-0020 6 1 ☐ Yes XX No Specify. Specify: WHITE by 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry se filed within 7 al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER TESTING COMPANY YEAR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fil h and Mental H ' Is marked oth FRANK D. HECKATHORNE **EDNA** COLLISTER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 s Department of Heelth ar Important: if Item 27 Is any Injury or other trau FRANCES H.MUELLER (SISTER) 830 WEST 40th. STREET, BALTIMORE, MD., 21211 Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremation X3 Removal from State EVERGREEN CEMETERY 10-18 PAINSVILLE, OHIO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) Ceremo Vescular Examiner Due to (or as a consequence of) Physician/Medical Examiner Limi Mation physician end the burial-trensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of) use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco ues contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Tunknown erten Olineese Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? Stomoria regungi Pation certificate 14 toll 1□ Yes 2 No 1 TYes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 200 Hospital: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Natural death. 1 Yes 2 No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examinsr: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier

Heckathorne

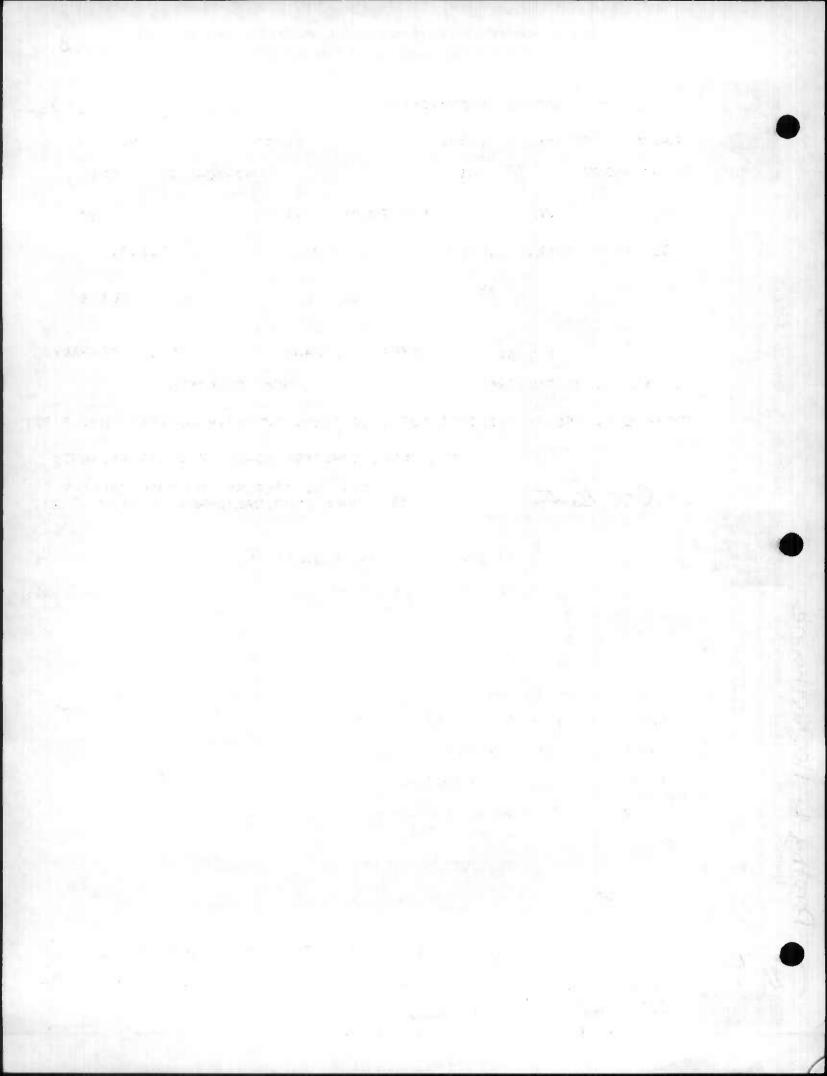
State Registrar



30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

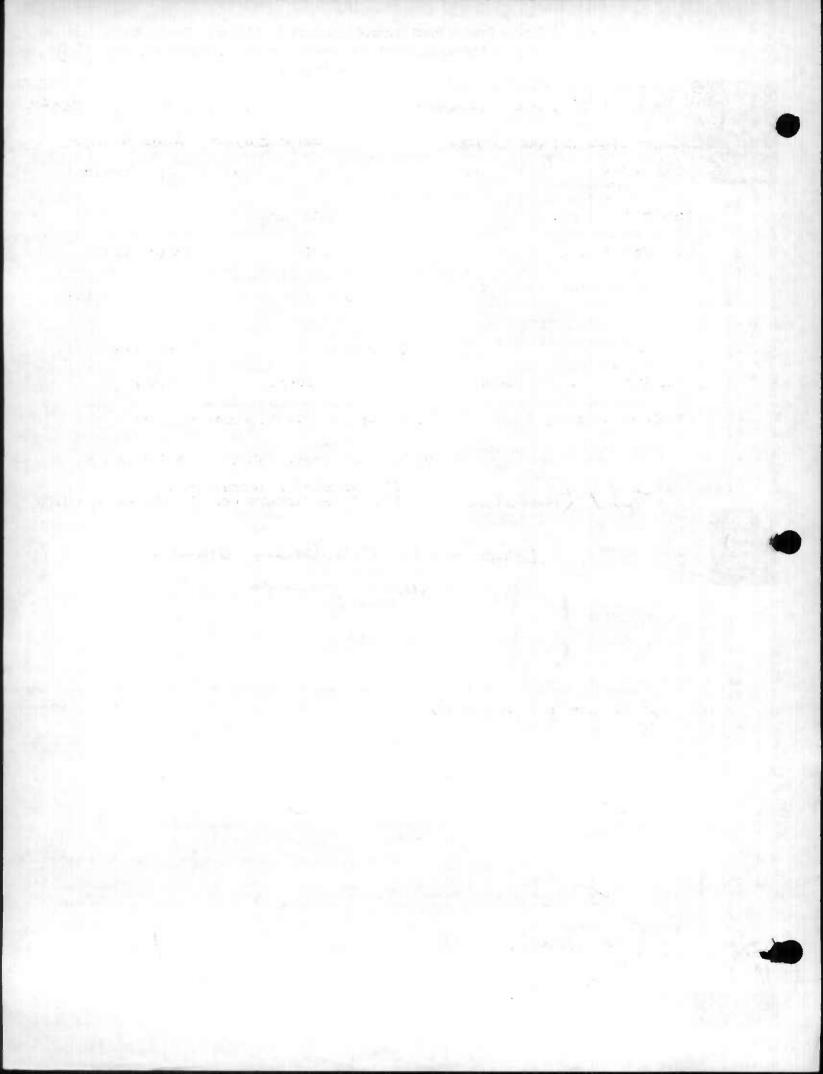
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DEMORIAL HUSPITAL , BALTIMORE , ND



State of Maryland / Department of Health and Mental Hygiene 7 30849

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23a or 28a-f s		10e. Street and Number 329 East Ave.				10f. Z	ip Coda 2	1224			og. Citizen of V United		*	
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within 24 hours a To the Funeral I completely filled Medical Ce		29a. Certifiar (Check only one)  1 □ Certifying Pl 2 □ Medicat Exa	nyatcfan: To the best of minar: On the basis of and manner sta	axaminatio	edga, d on and/o	aath occurre or Invastigatio	d at tha th	ma, data and opinion, daath	placa, a n occurre	and dua to tha ca ed at tha tima, da	usa(a) and ma ita and placa,	annar as st and dua to	atad. tha caus	e(s)
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The same	Funeral	11. Marital Status	erried 2 Married	12. Wes Dece Armed For 1  Yes If Yes, Give	ces? 2X No	U,S. 13	Was Decede if Yes, specif		Hispenic Origin? (Spen, Mexican, Puert	pecify Yes or No Rican, etc.)		ck, White	rican Indien, n, etc. White
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C . N			Neme/Relationship		siste				t and Number or Ru 142I Blu		ber, City or Town		ip Code)
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Department Important: If any Injury or once.		21. Signature of B	Funeral Service Lic	Haigh	4	1	22. Nama end HAIGHT	Addro FU	ess of Fecility NERAL HOM Le, MD 21	E & CHA	APEL (Bo	x 195	
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signed by the etten d be detached for u Physician by Completed page 2 To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifical completally filled in by the funeral director, it Be Certification:

Division of Vital Records, P.O.

Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy pertormed?

24b. Wara autopsy findings eveilable prior to completion of cause of daath? 1 Yes 2 No

25. Wes casa referred to medical examiner? 1 X Yes 2 No 27. Manner of Deeth

1 Naturai

2 Accident

30 Suicide

29a. Cartifian

4 Homicide

(Check only one)

28e. Date of Injury (Month, Dey Year) invastigation found 1D/8/97

Hospitei: 1 ☐ Inpatient 2 X ER/Outpetiant 3 ☐ DOA 28b. Time of Injury found A.

Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 28c. Injury et Work? 1 Yes XX No

28d. Describe how Injury occurred Subject took Drugs

1 Yes

28f. Location (Street end Number or Rural Route Number, City or Town, State/7110 Mathew St. Greenbelt, Md.

found: residence

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and piace, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature end title of cartifian

6 Could not be detarmined

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) OCTOBER 10, 1997

30. Name and eddress of person who completed cause of daeth (item 23a) (Type, Print)

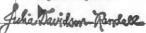
MAMYSOUTS A-KORFU MP 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

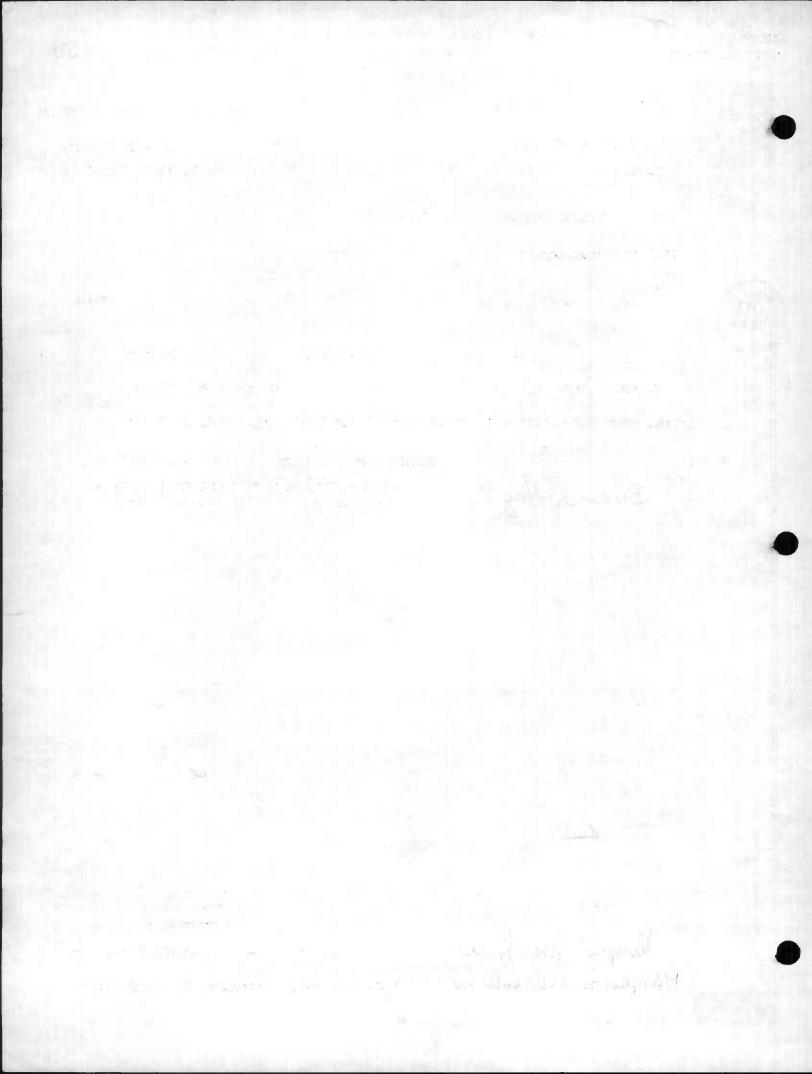
111 Penn Street, Baltimore, Maryland 21201

26. Plece of Deeth (Check only one)

State Registrar

Medicai

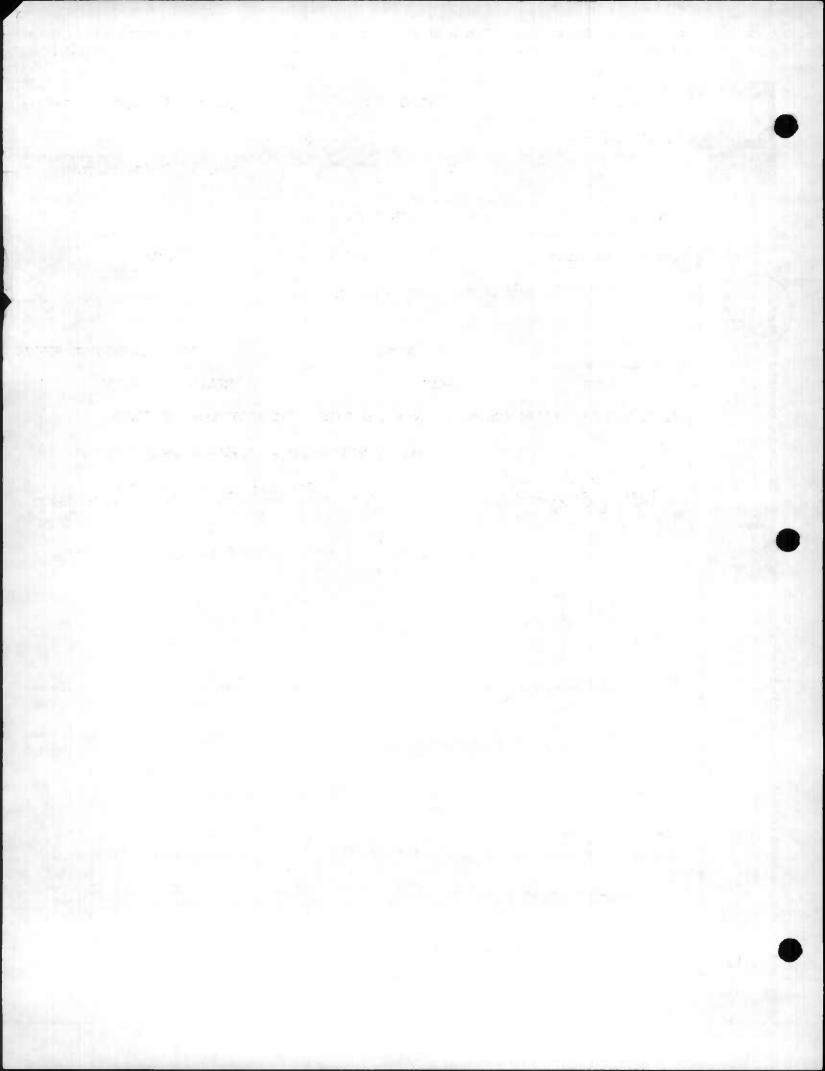




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7 3085 |

					Certific	ate of	Death		Re	g. No.			
Physic		Decedent's Name (First, Middle, Las     LEON	t)	HARR	IS				ate of Deeth		997	3. Time of Dec	
/Medi Exami		4e. Facility Neme (If not institution, give	street and number)				4b. City, Town	n, or Location		4c. County			Pill
Funeral Director		210-12-3733	XM 2□F	78 nyrs. last bir	thday) If Un Monti	der 1 Yaar hs Days	If Under 24		ote of Birth lonth, Day AN . 24	Year) 1, 1919	9. Birthpl	ece (State or Fo	raign
with the Maryland a or 28s-f show be notified at	tor	Usuel Residenca of Decedent  10a. State 10b. County  MARYLAND N/A		c. City, Town	or Location	DRE					10	0d. Inside City Li	
atter Boath with the 6r forms 23e or 28e moner must be noti	Funeral Director	10e. Street end Number  7124 BOXFORD ROAD  11. Marital Status  1 Xever Married 2 Married	12. Was Decedent Eve Armed Forces? 1 XYes 2 □ No If Yes, Give	r In U,S.	13. Was De	Zip Coda 21215 cedent of pecify Cut	Hispanic Origin ban, Mexican, I	n? (Specify Y Puarto Rican		Blac	e - America ak, Whita, a	an Indian,	
NH	eted by	3 Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grad	Yeer or Dates:	16a.	Decedent's I	suet Occu		of working	1	Specify 6b. Kind of Bu	WH.	ITE lustry	
212	Completed	Elementary/Secondery (0-12)	College (1-4or 5+)	1	AGENT	T use retire						ENUE SEF	(VI
and the fi	Be C	17. Father's Name (First, Middle, Last)  JACOB	HZ	RRIS			18. Mother's		, <i>Middl</i> e, M LLIE	aiden Sumam	BLOCK		
Maryland nd 2 should be file sith and Mental Hy 27 is marked other fraumatic event	To	19a. Informent's Neme/Relationship (T) MR. S. HERBERT HAR	ype, Print)	19b			ot and Number	or Rural Rou	te Number,	City or Town,	State, Zip	Code)	
Baltimore, ournil. Pages 1 an Department of Heal mportant: If New 3 any Injury or other attes.		20a. Method of Disposition  1 23 Burlal 2 Cramation 3 4 Donation 5 Other (Specify,	Removal from State	20b. Place of cemeter	Disposition (i	Name of or other pla		Dat	e 2	Oc. Location -	City or To	wn, Stata MD	
A DEVICED PROPERTY OF THE PROP	ai Examiner	23a. Purt1. Finter the disease, or companded or hart failure. List only disease or condition resulting in deeth)  Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Ceuse, (Disease or injury	a	e fuel		(Ce)	nees e					Approximate Intervel Between Onset end Deat	9
Centifi centifi ding	sian/Medical	that initiated events resulting In deeth) Lest	d.	to (or as a c	onsequenca c	of):							
hat the od by the detached	by Physician/	Part II. Other significant conditions con		ot resulting In	tha underlyin	g causa g	iven in Pert I.	2		ecco use cor		the cause of de ably 4 Unk	
of Attending Physician: The law requires that the death effect death.  Director: After this certificate has been signed by the atter tin by the funeral director, page 2 should be deteched for	Completed b							2	4a. Wes an perform	autopsy ed?	eva	re eutopsy findir illable prior to npletion of causi leath?	
ysician: The lavysician: The lav									1 🗆 Yes	2 CLM5	1□	Yes 2□ No	
sician: The certificate	To Be	25. Wes case referred to medical examiner?	Hospital:	of Delan	tpatient 3	DOA Ot	har	f Deeth (Che		) ice 6 □Oth	as (Canali		
VISION OF VICE Attending Physician: or death. ector: After this certific by the funeral director,		27. Manner of Deeth  1	28e. Date of Injury (Month, Day Ye			28c. tnju		28d. D		v Injury occurr		7	
LIVISION lat or Attending I s effer death. al Director: After ed in by the fune	Certification:	3 Sulcida 6 Could not be determined	28e. Pleca of Injury building, etc. (S	At home, fai	rm, street, fec	tory, offica		28f. Lo	cation (Stre ity or Town,	et and Numb State)	er or Rura	Route Number,	
To the Hospital or A within 24 hours effer To the Funeral Direc completely filled in by	edicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	elclan: To the best of m ner: On the basis of exa end manner stated	mination end	death occurr Vor investigati	ed at the ti ion, in my	ime, date and popinion, deeth	oleca, and du occurred et t	e to the car he time, dat	/se(s) end me e and pleca, o	enner es st end due to	ated. the cause(s)	
To the within 2 To the comple	Σ	29b. Signature end time of certifier	Bener	m			sa number	1		d. Date signed			
V		30. Neme and eddress of person who co	ompleted cause of death	(ttem 23e) (	Type, Print)		m n		ma	121	111	7	Ī
Sta	ite	31. Date filed (Month, Pay, Year)	films and and selling	Signature									



State of Maryland / Department of Health and Mental Hygiene Q 7

		- 9	Decedent's Name (	First Middle La	at)		С	ertificate of	Death	2. Data of Dea	eg. No.	3	3. Time of Death
	Physici		William	Louis		ber				Month October	Day	Yaar 997	8:30 am
	/Medic		4a. Facility Name (If n						4b. City, Town, or L		4c. County		0.30 alli
	LAGIIII	161	14 Clover Av	enue					Baltimore (	County	Baltin	ore	
	Funeral Director		5. Social Security Nun 214–20–8471	6. S	ex M 20F	7. Aga (In yrs. 72	last birthda Yrs.	Months Days	Undar 24 Hrs.		Year) 3,1925	9. Birthp Copri Baltin	placa (State or Foreign nore Co., Md
yland	how		Usual Residence of D 10a. State 1	ob. County		10c. Cit	y, Town or	Location				1	0d. Inside City Limits
Mar	Hell	ctor	Maryland E	Baltimore		Balt	imore	County					1 ☐ Yes 2 ☐ No
h with th	23a or 28	al Director	10e. Street and Numb					10f. Zip Code 21220			0g. Citizen of N	What Cour	ntry?
U KIKIO-UUKU Illed within 72 hours after death with the Maryland	Deperment of Heelih and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examinat must be notified at angle.	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4		12. Was Deced Armed Ford 1 X Yes 2 If Yes, Give Year or Da	cas? 2 □ No		3. Was Decedent of If Yes, specify Cult 1 ☐ Yes 2/□(No		pecify Yas or No- pecify Yas or No- pecify Yas or No- pecify Yas or No-		ck, White,	en Indian, atc.
2 Po	Tical I	ted	(Specify	5. Decedent's Ed only highast gra	ucetion	144 11		cedent's Usual Occu ive kind of work done b. DO NOT use retire	pation	king	16b. Kind of B	usinass/Ind	dustry
d within	r than "r	Completed	Elementary/Second		College (1-N/A	4or 5+)		Employed	ed)		ast Char	ice Bai	r
2 8	Mental Hygi arked other atic event, t	To Be C	17. Father's Name (Fit George Huber	rst, Middle, Last)					18. Mother's Nam Elsie Clas	ne (First, Middla, i S <b>in</b> g	Maiden Suman	10)	
should	a mar		19a. Informant's Nam	e/Relationship (7	ype, Print)		19b. Ma	ailing Address (Stree	t and Number or Ru	ral Route Number	, City or Town,	State, Zip	Code)
	Heelth em 27 i		Alma M. Huber	(Wife)				lover Avenue		e, Maryland	21220		
S	nt: If iten ry or oth		20a. Method of Dispos 1 X Burial 2 0 4 Donation 5	Cremation 3				sposition (Name of rematory or other planch ch Cemetery			20c. Locetion - Baltimore		
permit. Page	Depertra Importa any inju		21. Signatura of Fune 23a. Part 1. Enter the shock, or heart f	dans	bo Ch		Do not	7401 Bel	Funeral H air Road	Baltimor	e, Mary	land	21236-462 Approximate
//\	ysician Medical aminer		Immediate Cause (Fir disease or condition resulting in death)		a. ACUTE	MYOC	ARDI	AL INFAF				6	Interval Between Onset and Death HOURS
p	S.	iner			CONGE	STIVE	CAR	DIOMYOPA	ATHY			18	YEARS
rtificata be executed	ng physicien and as the buriel-transit	Medical Examiner	Sequentially ilst cond if any, leading to imm cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) Last	tions, ediate ing ury	0.	OSCLE	ROTI	sequence of):  C CARDIC sequence of):	OVASCULA	R DISE	ASE	8	3 YEARS
5 E	tendir or usa	an			d								
requires that the death cer	ed by the attending p detached for usa as	Physician/N	Part II. Other signification ATRIAI					e underlying ceuse g		23b. Did to	Α.		the cause of death bably 4 Unknow
Attending Physician: The law requires the	been sign should be	Completed by	MITRA	REGUE	RGITATI	ON				24a. Was a perfor	n autopsy med?	av	ere autopsy findings allable prior to impletion of ceuse death?
The law	a has	ошо								1 🗆 Y	es 200 No		Yes 2 No
ü	tificat tor, p	Be C	25. Was cese referred	to medical					26. Place of Dea	th (Check only or			3100 2010
Physician:	er this certificata has eral director, pege 2	2	examinar? 1 Yes 2 No. 27. Manner of Death		28a. Date of		ER/Outpat 28b. Time	of 28c. Inju	ther: 4 Nursing H	oma 58 Reside	ence 6 🗆 Oth		(y)
Attending	death. ctor: After y the funer	Certification:	2 ☐ Accident 3 ☐ Suicida	5 Pending investigation 6 Could not be determined			Injur		Yes 2 No	28f. Location (S	treat and Numi	per or Rura	al Routa Number,
1	200		4  Homicide	determined	buildin	g, etc. (Specif	y)			City or Tow			
1	Se Funda	edical	29a. Certifier 1 (Check only 2 one)	Descritying Phy Medical Exam	ysician: To the b linar: On the bas and mann	sis of exemine	wledge, de tion end/or	eath occurred at the to investigation, in my	ime, date end place opinion, deeth occu	, and dua to the c rred et the time, d	ause(s) and ma ate and place,	anner as s end due te	tated. the ceuse(s)
Ton	00	M	29b. Signature and titl	e of Conflict					sa number		9d. Date signe		
)	X			Hoh	D.O.			Н355	93	0	CT. 13	3, 19	997
	6		30. Neme and eddress	MACE_A					21				

Registrar

A CONTRACTOR OF THE PARTY OF TH

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 20bc per FH Film G752 10-14-97 rja Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Isler Vickie OCTOBER 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth HOSPITAL CiTy BALTIMORE HOPKING NIA Johns if Under 1 Yeer Months Deys 7. Age (In yrs. last birthday) 39 Yrs. Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
OCT. 20, 1957 5. Social Security Number 9. Birthplece (Stete or Foreign Country)
MARY LAND 1□M 20€F Hours Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits NIA 1X Yes 2 □ No MARYLAND BALTIHORE 10e. Street end Number Og. Citizen of What Country? 2734 STREET ARKWOOD 21217 USA. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 XNo 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorcad Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) BA DEGREE BANK MANAGER LEGG MASON 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) MCKINNIS WILLIAMS SHIRLEY WOOD 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, Stete, Zip Code) Dete | 20c. Location - City or Town, Stete | ARBUTUS ELISHA ISLER AD) 1210 N, CALVERT ST, cometery, cremetery or other place UTS (HUSBAND) 20a. Method of Disposition

10 Burlel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) - CEMETERY 10-13-97 LANDSDOWNE, HD. 22. Name end Address of Fecility JOSEPH H. BROWN JR. FUNERAL HOME, P. A. 2140 N. FULTON AVE. BALTIHORE, NO. 21217 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Hypoxia 2 days Due to (or es e consequença of): Respiratory Distress Treumonia (Aspiration Due to (or es e consequence of): Bleed GI 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown induced 24e. Wes en eutopsy performed? 24b. Were eutopsy findings aveilable prior to completion of cause of death?

1 Yes 25 No

29d. Dete signed (Month, Day, Year)

Baltimore.

**Physician** /Medicai Examiner

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

à

Completed

Be

**Funeral** 

Director

r 28a-f s notified

8

or Items 23a

should be filed within 72 hou and Mental Hyglens. a marked other than "natura umatic event, the Medical E.

permit. Pages 1 and 2 should be file Department of Health and Merrial Hy Important: If item 27 is marked other any injury or other traumatic event

Baftimore, Maryland 21215-0020

Examiner Physician/Medical ò Completed paga 2 funeral director. Be Certification: To in by

Medical

or Attending Physician: The law requires that the death certificate be axecuted

certificata

this

After

24 hours after death.

Hospital

Box 68760,

P.O.

Division of Vital Records.

Immediete Cause (Final diseese or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Tyes 2 № No 25. Wes case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel 1 | Yes 2 | No 2 Accident 3 Suicide 6 Could not be Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1≅ Certifying Phys 2□ Medical Examp 29a, Certifier tials. To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the cause(s) and menner es steted.

within 24 hor To the Fune completely fi ŝ 0

W Bowerfind 31. Dete filed (Month, Day, Year) State 199 14 Registrar

(Check only one)

29b. Signature and tipe of partition

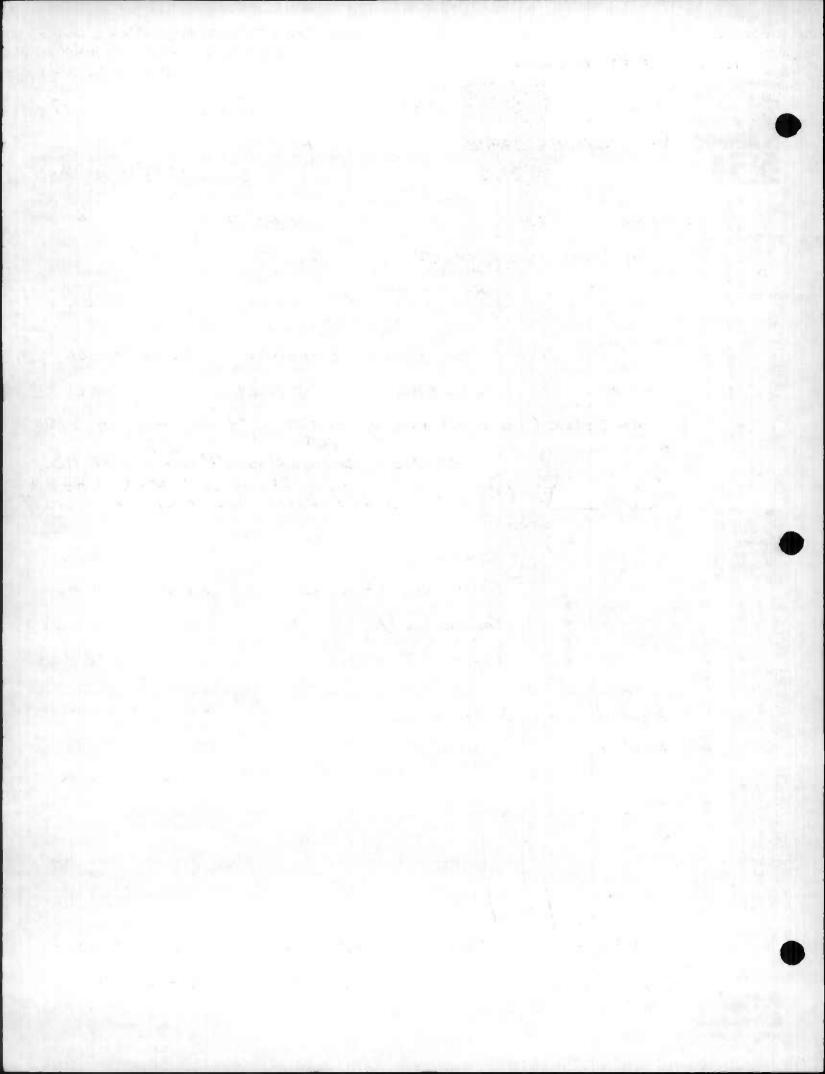
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

600 N. Wolfe St Tower 110 32. Registrer's Signeture was Davidson-Randell

On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

KES-000

29c. License number



State of Maryland / Department of Health and Mental Hygiene

	100	Decedent's Name (First, Middle,	Last)		Cel	unca	ile of l	Death	10	Re Data of Death	g. No.		3. Tima of Death
Physici /Medi		Ruth	E.			Jo	hnso			Month OCTOBER	9, 19		1:05PM
Examir	ner	<ol> <li>Facility Nama (If not institution,</li> <li>1735 NORTH BONI.</li> </ol>		nber)			4	b. City, Town, BALT IM		tion of Death	4c. County	of Death	
uneral rector				7. Aga (In yrs	lest birthdey) Yrs.	If Und Month	er 1 Year Days	If Under 24	Hrs. 8	Date of Birth (Month, Day,			ace (Steta or Foreign y)
Fedal	tor	Usual Residence of Decedent  10a. State 10b. County  MD	NA	10c. C	ity, Town or Lo Balti		e						d. Inside City Limits 1   Yes 2 □ No
23e or 28	ai Director	10e. Street and Number 1735 North B	ond Str	eet			ip Coda 1213			10	g. Citizen of V	Vhat Count	ry?
el', or items 23e or 28e-f show Examiner must be notified at	by Funeral	11. Marital Status  1 Navar Married 2 Marrie  3 Widowed 4 Divorced	12. Was Dece Armed For d 1 Yes If Yes, Giv Year or Da	rces? 2 X No			edent of H ecify Cuba 2 No	ispanic Origin in, Maxican, P Specify:	? (Specif uerto Ric	y Yes or No- can, etc.)		e - America ck, White, e	
than "naturel", he Medical Exz	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education greda completed) College (1	-4or 5+)	16a. Deced (Give life. L	lent's Us kind of v DO NOT	ual Occup rork done o use retired	ation during most of ()	working	1	6b. Kind of Bu	ısin <b>a</b> ss/Indu	ustry
vent, I	Ве Соп	11th Grade 17. Father's Name (First, Middle, L	NA		N	urs	ing	18. Mother's	Name (F	B First, Middle, M			sing Ctn
s marke sumetic	То	Thomas 19a. Informant's Name/Relationshi Lucille Gros		Whi	19b. Mailin				r Rural F	Route Number,	City or Town,		
r other		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	3 □Ramoval from 5	State	Place of Disponentery, cremo	sition (N	eme of othar plac	:e)		Date 2	0c. Location -	City or Tow	m, State
Important: If any injury o		21 Storture of Funeral Service Li 23a. Part1. Enter the disease, or c ahock, or heart failure. List o	Lairs	aused the dea	W	M.C	. Ma	ss of Facility  rch F	H 1:	LO1 E.	Nort	h Ave	nd 21202 enue Approximate
/sician ledical aminer		ahock, or heart failure. List o  Immediate Cause (Final disease or condition resulting in death)		eriosc	lerotic	Car	diova						Intervat Between Onsat and Death
physician and s the burlat-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertyling Causa (Disease or Injury	b		or as a conseq				H			-	
0 8	Medical	Causa (Disease or Injury that initiated events resulting in death) Last	c	Due to (	or as a consequ	uence of	):						
igned by the attendi	/ Physician/	Part II. Other eignificant condition	s contributing to de	ath but not re	sulting In the ur	nderlying	cause giv	en in Part I.			s 2 No		the cause of death?
s been sign 2 should be	ompleted by									24a. Was an perform	autopsy ed?	com	re autopsy findings labla prior to spletion of cause eath?
age age	e Com	05 W								INSPEC	s 2LXNo		Yas 2XXVo
itter this certifical uneral director, p	ToB	25. Was case raferred to medical examinar?  1) Ness 2 No  27. Manner of Death  1 Ness 2 Pending		npatient 2 [ of Injury h, Dey Yeer)	ER/Outpatien 28b. Tima of Injury		28c. Injun Work	er: 4□ N <i>u</i> rsir y at k?	g Home	5XXResider  d. Describe how	nca 6 Oth		
of in by the	ertification:	2 Accident investige 3 Sulcide 6 Could no 4 Homicide determin	t be 28e. Placa	of Injury - At h	nome, farm, stre	M eet, facto		Yes 2 □ No	281	Location (Str. City or Town,		er or Rurel	Route Number,
Funeral proty like	edical C	29a, Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the caminer: On the ba	sis of examina	owledge, death ation and/or inv	occurre	d at the time, in my of	ne, date and p pinion, death o	lace, and	due to the car at the time, da	use(s) end ma te and placa,	nner as sta and due to	ited. the cause(s)
A C	M M	29b. Signatura and titla of certifier	and main	o. stateu.		2	9c. Licens	a number		20	d. Data signa	d /Month C	No. Vons

State Registrar

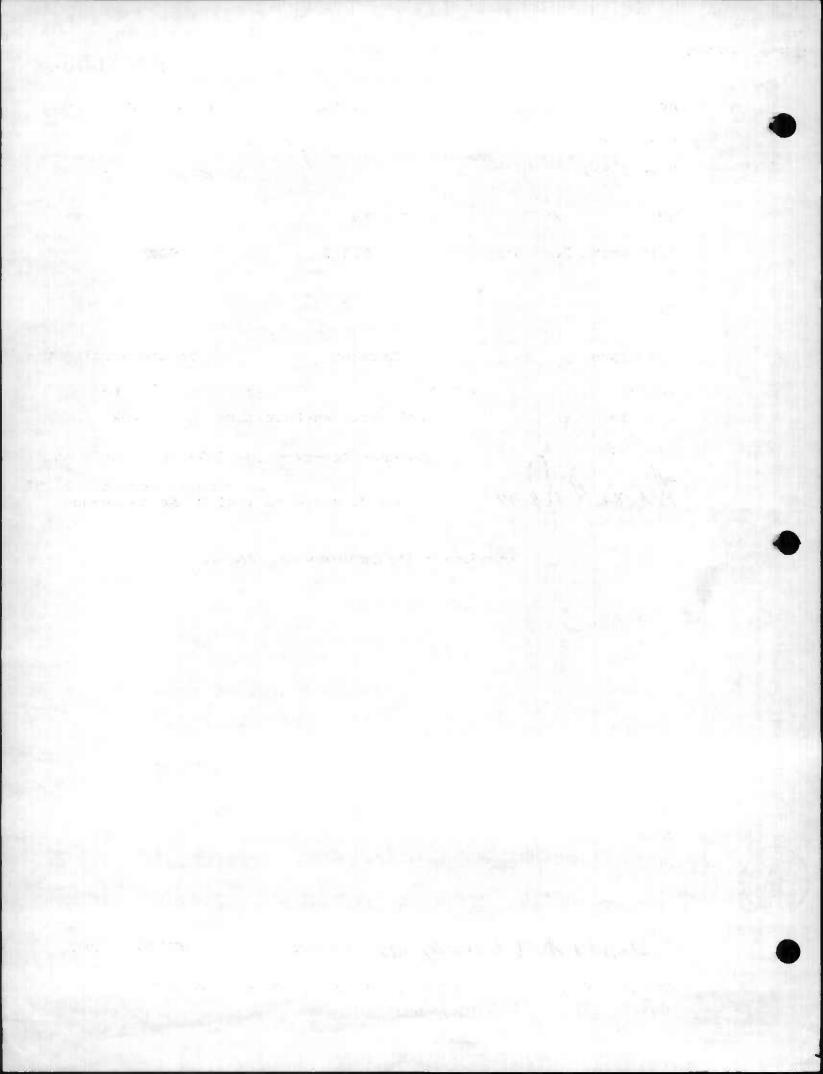
30. Name and address of person who completed cause of death (Item 23d) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201
32. Registrar's Signature

O.C.M.E.

OCTOBER 9, 1997

STEPHEN RADENTZ M.D.
I. Date fled (Month, Day, Year)

14 1997



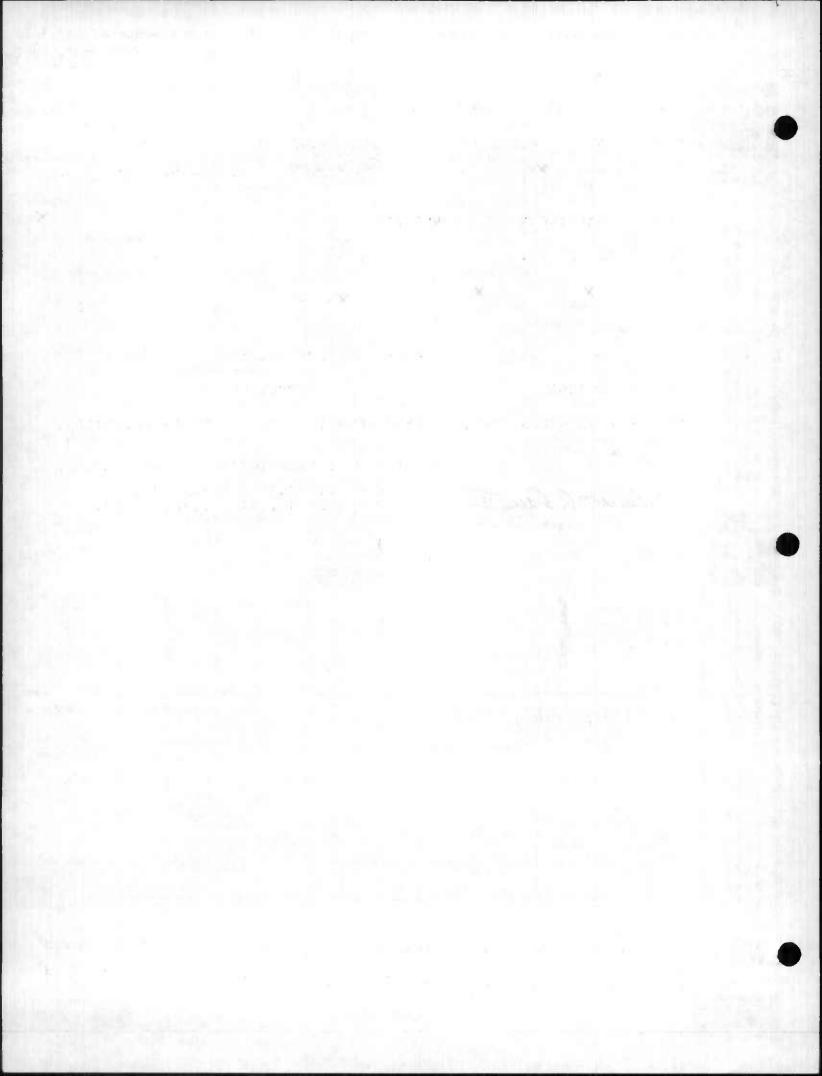
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nysician		1. Decedent'e Neme (First, M	liddle, Last)								2. Dete of Dee Month	th Dey	Y	eer :	3. Time of Death
Medical	L	Margaret Emm									<b>October</b>	^ 3,	1997		9:45 AM
xaminer	ľ	te. Facility Neme (If not Institu									cation of Deeth	4c. C	ounty of		
		Franklin Woo 5. Social Security Number	ds Nu		1	s. lest birthde	a) If I In	der 1 Year		ville r 24 Hrs.				timo	
neral ector	2	218-12-8604 Usuei Residence of Deceden	1[	M 2[XF	7. Age (III y/	92 Yrs.	Monti			Min.	8. Dete of Birth (Month, Day January 15	, 190	5 N	Country lary la	e (Stete or Foreig and
		10e. Stete 10b. Cou			10c. 0	City, Town or I	Location							10d.	Inside City Limit
Director			timor	.e		Rossvi		m. 11							1 ☐ Yes 2 🛣 N
Examiner number nearled at by Funeral Director		10e. Street end Number						Zip Code			1			et Country	
Funeral	-	9200 Franklin		12 Was Dec	edent Ever In	U.S. 13		1237	Hispanic O	rigin? (Spe	cify Yas or No-			American	
by Fun		1 Never Merried 2 1 1 3 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Merried	Armed Find Yes if Yes, Given or I	orces? 2 No ive			specify Cub s 2 K No			city Yes or No- Rican, etc.)			White, etc	
Be Completed			dent's Edu			16a. Dec	edent's U	suel Occu	petion	at at wastel		16b. Kind	of Busin	ness/Indus	try
a le	-	(Specify only high			1-4or 5+)				during mo	St Of WORK	ng .				
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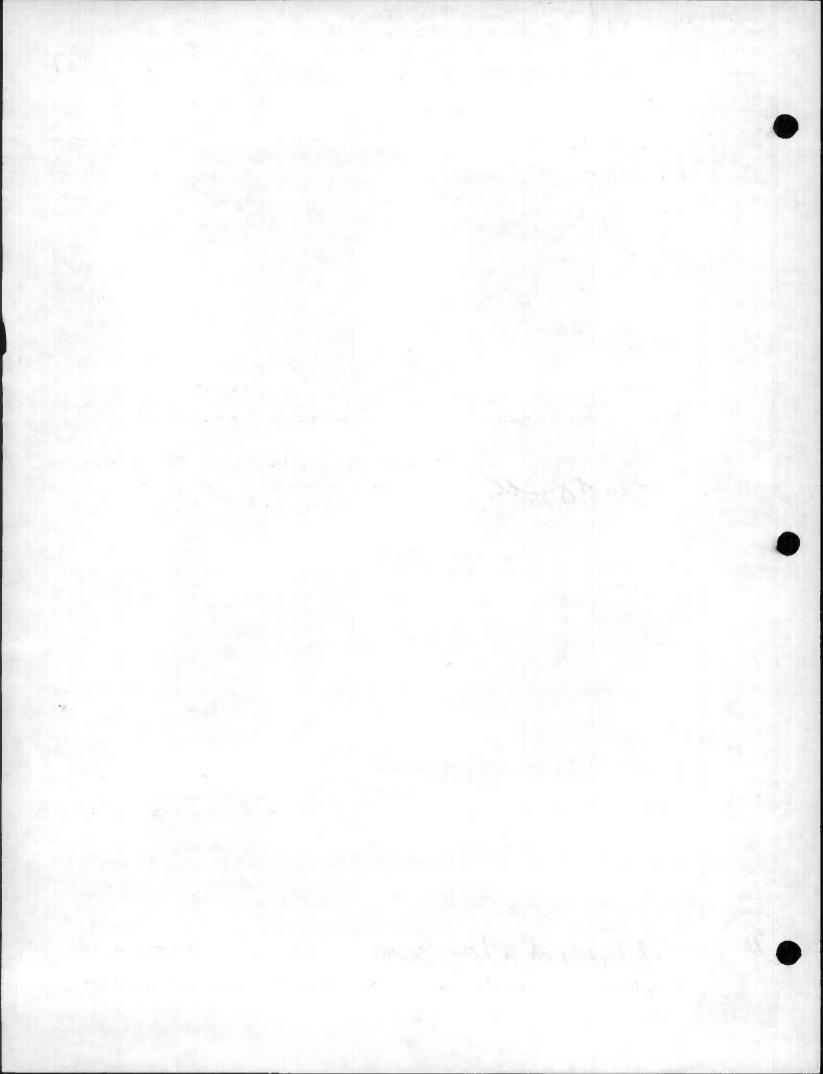
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month HARRY 5. 6:30 am JACOB SON 1997 oct 13 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10-26-1906 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15 M 2 F 212-05-7040 90 Yrs. Director NEW MEXICO Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Maryla notified at Director 1 Yes 2 No BALTIMORE PARKVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? b Examiner must be 2819 ROSALIE AVE. Herns 23s 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 72 hours after 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural', or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No by 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent'a Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondery (0-12) 2YRS GROCERY STORE OWNED GROCERY BUSINESS permit. Pages 1 and 2 should be flie.
Department of Health and Mental Hygh
Important: If item 27 is marked
any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) JACOB JACOBSON ESTHER BENSEN 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA JACOBSON(WIFE) 2819 ROSALIE AVE. PARKVILLE, MD. 21234. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MORELAND MEM. PARK 10/16/97 PARKVILLE, MD. 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility HENRY W. JENKINS & SONS CO. William K. Kares III 4905 YORK RD. BALTO., MD. 21212. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. **Physician** /Medicai Immediate Cause /Final eps13 3 Weeks disease or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner physician and the bunal-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of): esn P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Disease Records, þ Completed 24a. Was an eutopsy 24b. Were autopsy findings peen Cancer aveilable prior to completion of cause of death? page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medicei examiner? 28. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? After 1 Naturel 5 Pending 24 hours after death. Funeral Director: A 1 TYes 2 □ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Hospital 29a. Certifier edical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. tely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Withir To th 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 2 P10589 Mmgrand eddress of person who completed cause of death (Item 23e) (Type, Fint) The Good Samaritan Hospital of Maryland. MD Kharfan 196019 22. Registrar's Signature 31. Date filed (Month, Day, Year) State who Davidson Randall Registrar



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Physician /Medical Examiner		23a. Pert1. Enter the disease, or comp shock, or haert failure. List only of Immediata Cause (Final disease or condition resulting in death)	ne causa on each line.  NARCOTIC	INTOXICAT	ION	ng, such es cerdiac	or respiratory en	est,	Inter	roximete val Batween et end Death
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15	ite	30. Nema and eddress of person who could be seen and eddress of person who could be seen and	ompleted ceusa of daath (Item a dentz, m.) 32. Registrer's Signe	0 111 Pe		eet, Balt				



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:03 Am KATHERME JOHNSON 10 97 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Catonsui 11-0 BALLIMORE Home 5. Social Security Number Haveh 6. Sex 1259 If Under 1 Year 7.(Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 10 M 2 F Months 36-36. Yrs. 04 5300 01-28 Usual Residence of Decedent 10b. County 10c. Qity, Town or Location-10d. Inside City Limits 1 Yes 2 No mor 10e. Street 10f. Zip Code 10g. Citizen of What Country? Me Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) Was Dec 1 ☐ Yes 2 ☐ No If Yes, Give ever Married 2 Married Specify: BlAC 1□ Yes 2□No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) mes 70 0 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, ALLACE GOVANS resecce 19b. Mailing Address (Street end Number or Rural Route Number) City or Town, State, Zip Code) 19/0 Informant's Neme/Relationship (Type, Print) 20b. Plece of Disposition (Neme or cemetery, cremetery or other 20a. Method of Disposition 1 Deurial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Company on mondson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death SEPTICEMIA Immediate Cause (Final disease or condition resulting in death) 11 days NEUMONIA Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that Initieted events resulting In death) Last Due to (or es a consequence of) Part II., Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably Unknown IABBTES MELLITUS 24b. Were autopsy findings evailable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 2 1 No 20 No 1 Yes 1 Yes

**Physician** /Medical Examiner

pemit. Pages 1
Department of H
Important: If its
any injury or ot

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

by

Be Completed

2

**Funeral** 

Director

th and Mental thygiene. 7 is marked other than "natural", or fisms 23s or 28s4 show treumetic svent, the Medical Examinat must be notified at

Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
and: If item 27 is marked other than "natural", or items 23 ury or other traumatic avent, the Modical Eservie many or other traumatic avent, the Modical Eservie man

21215-0020

Baltimore, Maryland

P.O. Box 68760,

Records.

Division of Vital

Attending

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the Hospital Inin 24 hours the Funeral

E O

be

the Maryland

Physician/Medical Examiner å Completed Be 2 Certification: death. after death Director:

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Medical

PV

25. Was cese referred to medical exeminer? 1 Yes 2 No 27. Manner of Death Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

Hospital:

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

28d. Describe how injury occurred Location (Street end Number or Rurel Route Number, City or Town, State)

Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end menner es steted.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

28c. Injury at Work?

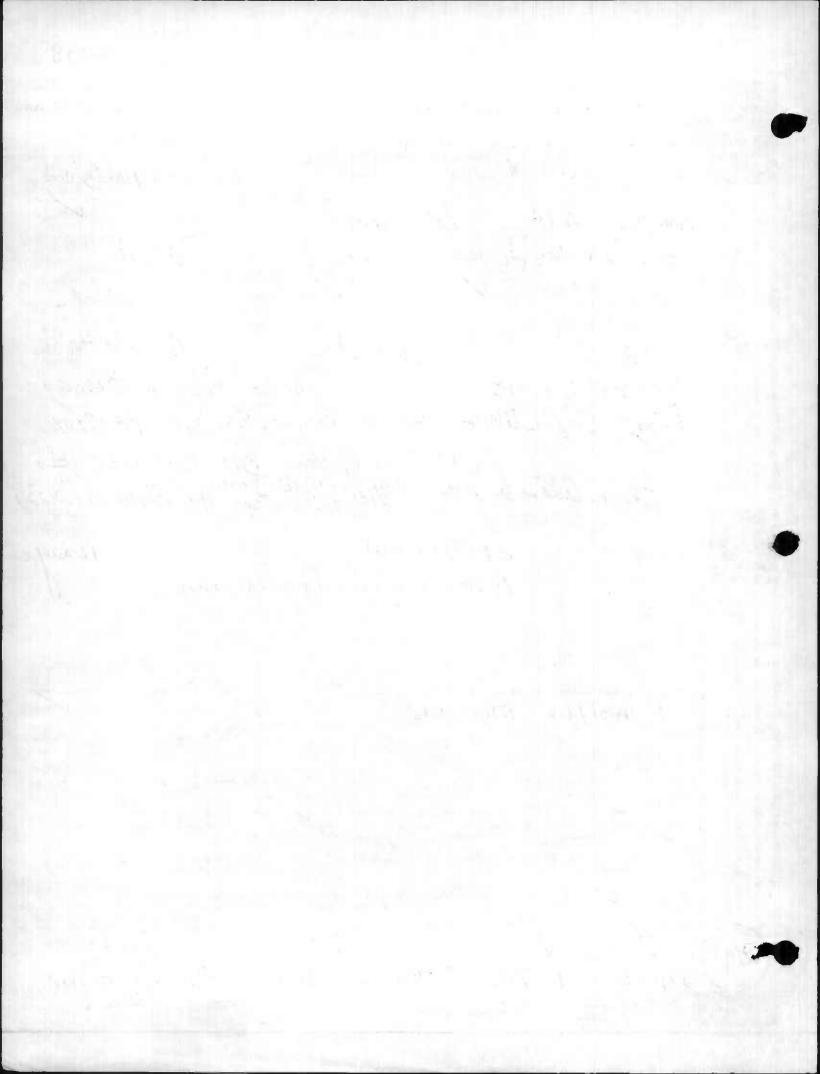
29d. Date signed (Month, Day, Year)

completed cause of deeth (Item 23e) (Type, Print)

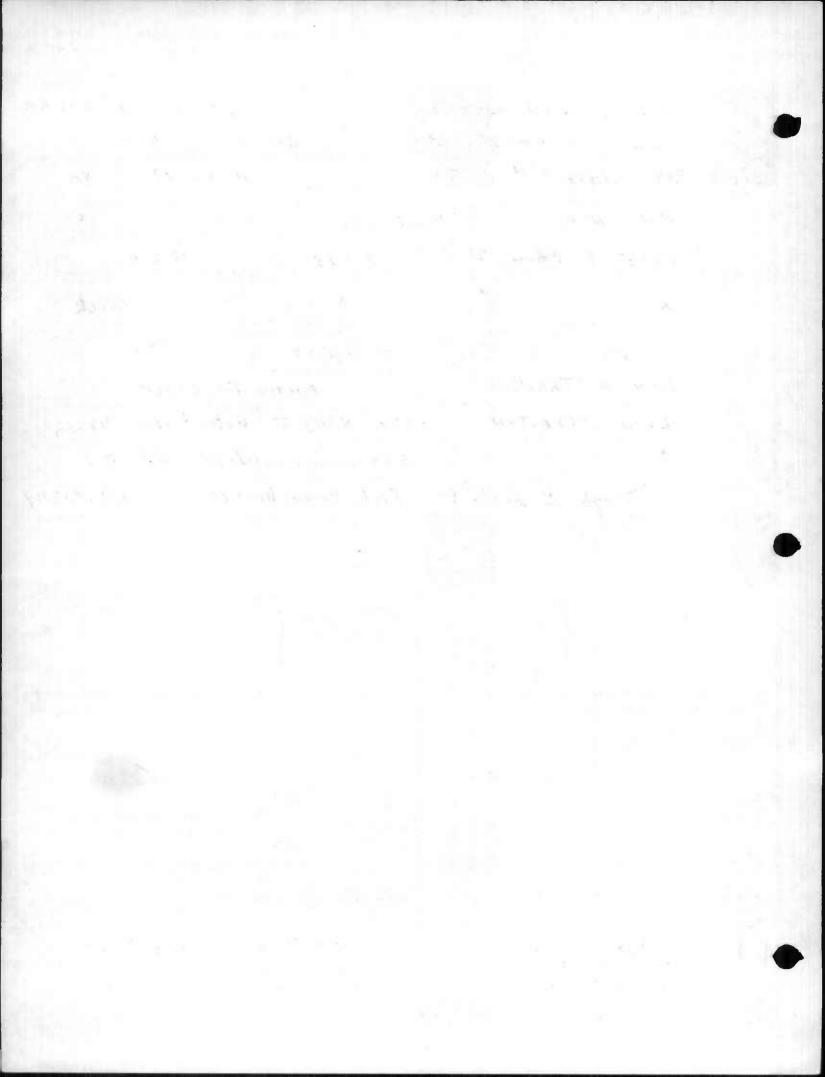
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State Registrar 4 1997

32 Begistrar's Signeture



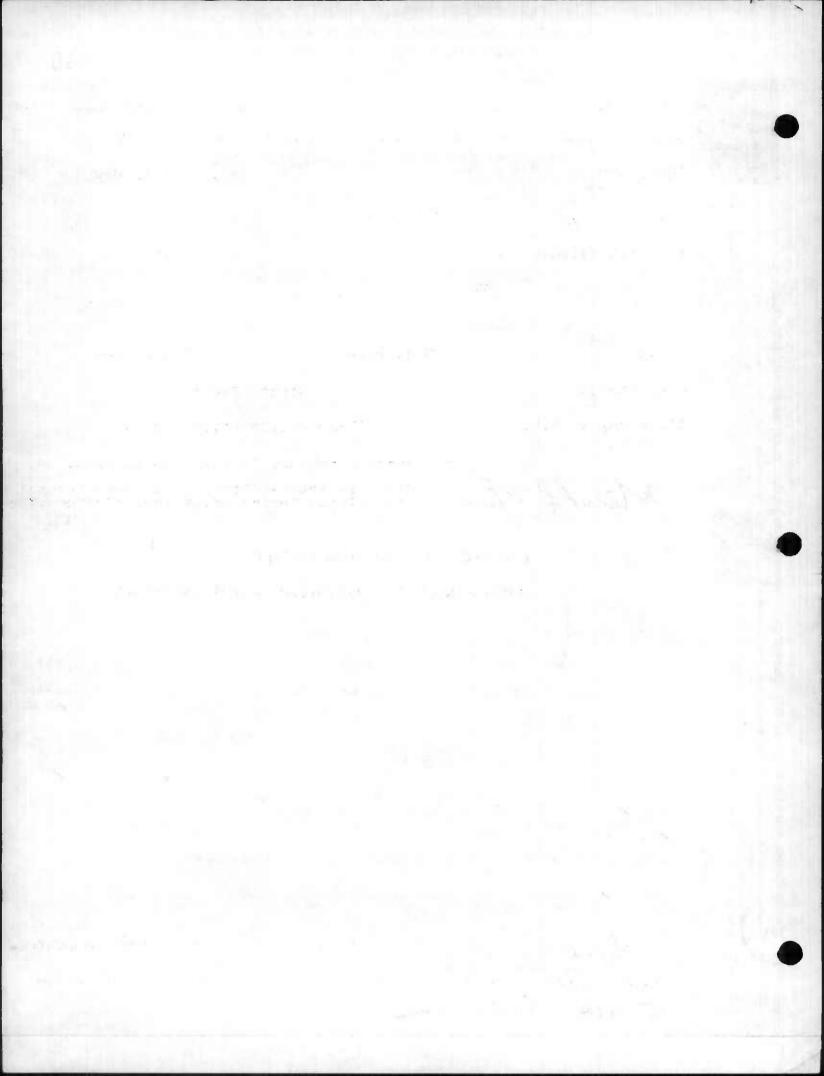
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State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 3086 I Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 1997 Chai Chavelle Lillian KIRKLAND October 10:30 P.M. /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Franklin Square Hospital Center Baltimore Rosedale 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 1 F Yrs. Director none 35 Oct 8, 1997 Maryland Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland 1 ☐ Yes 2 No Harford Aberdeen 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 158 Allendale Avenue 21001 U.S.A. Funeral 12. Wes Decadent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours efter 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 X Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) none 0 none-infant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumetic event, once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Agustus Kirkland 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code, Sharon Reed 158 Allendale Avenue, Aberdeen, Maryland 21001 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donetion 5 ☑ Other (Specify) in state 21. Signeture of Funeral Service Located Sonald S 22. Name and Address of Facility Board, 655 W. Baltimore Street Director anous Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Betw Onset end Deeth **Physician** /Medical Immediate Cause (Finel Preterm Birth at 195/7 weeks Gestation diseese or condition resulting in death) 35 minutes Examine Due to (or es e consequence of): Examiner physician and the bunal-transit be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequenca of): Physician/Medical Due to (or es e consequence of): resulting in deeth) Lest for use es 80 Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of ceuse of death? Completed 24e. Wes en eutopsy performed? peen page 2 s 1 ☐ Yes 2 No cartificate 1 Yes 2 No or Attending Physician: after death. Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending 1 MNaturel 2 Accident 1 Tyes 2 □ No investigation within 24 hours after death To the Funeral Director: completaly filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 | Homicide Hospital 12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as steted.

2 Medical Examiner; On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. Medical 29e. Certifier (Check only one) 29d. Dete signed (Month, Day, Yeer) 29b. Signeture end title of cartifier 29c. License number 10 RD 2093 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar Dr. Lisa Miller

141997

31. Dete filed (Month, Day, Year)

OCT

32. Registrer's Signeture
Julia Dividson-Randall

9000 Franklin Square Drive Baltimore, Md. 21237

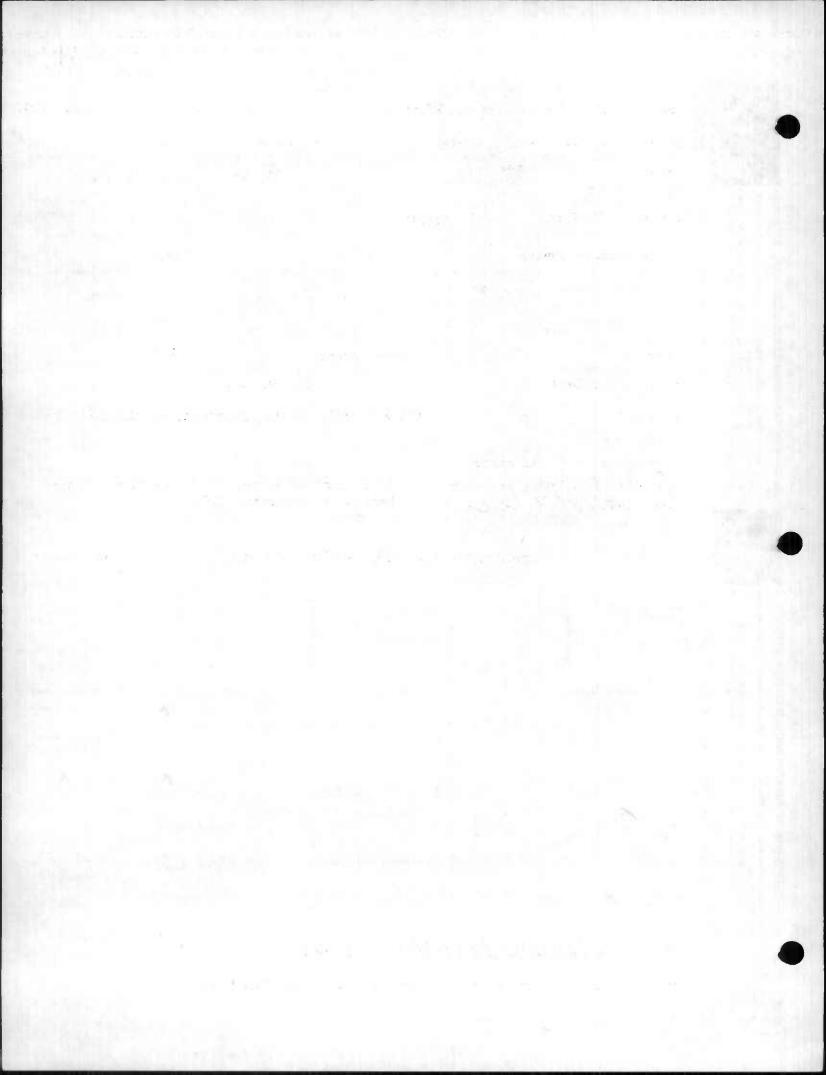
Baltimore, Maryland 21215-0020

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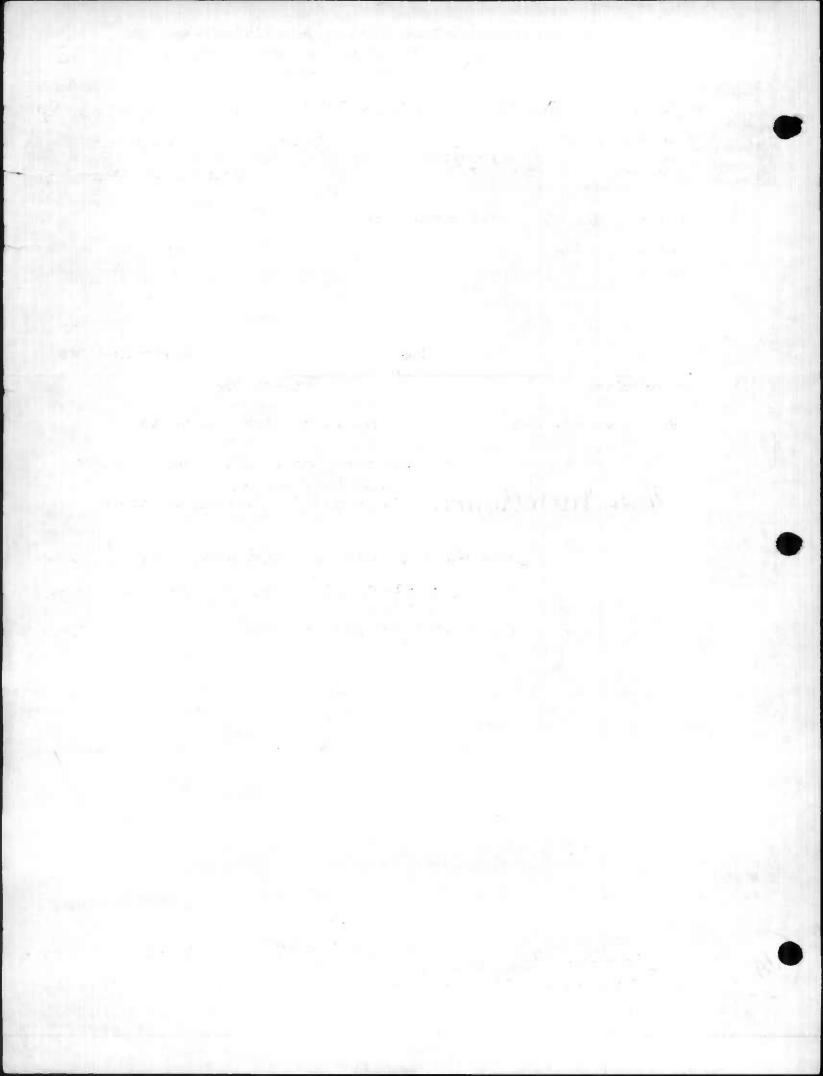
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erai ctor		216–14–3491 Usual Residence of Decedent	4011 405	73	Yrs.	Months Day		(Month, De	14, 1923	Baltimor	(State or Foreign re,Maryland
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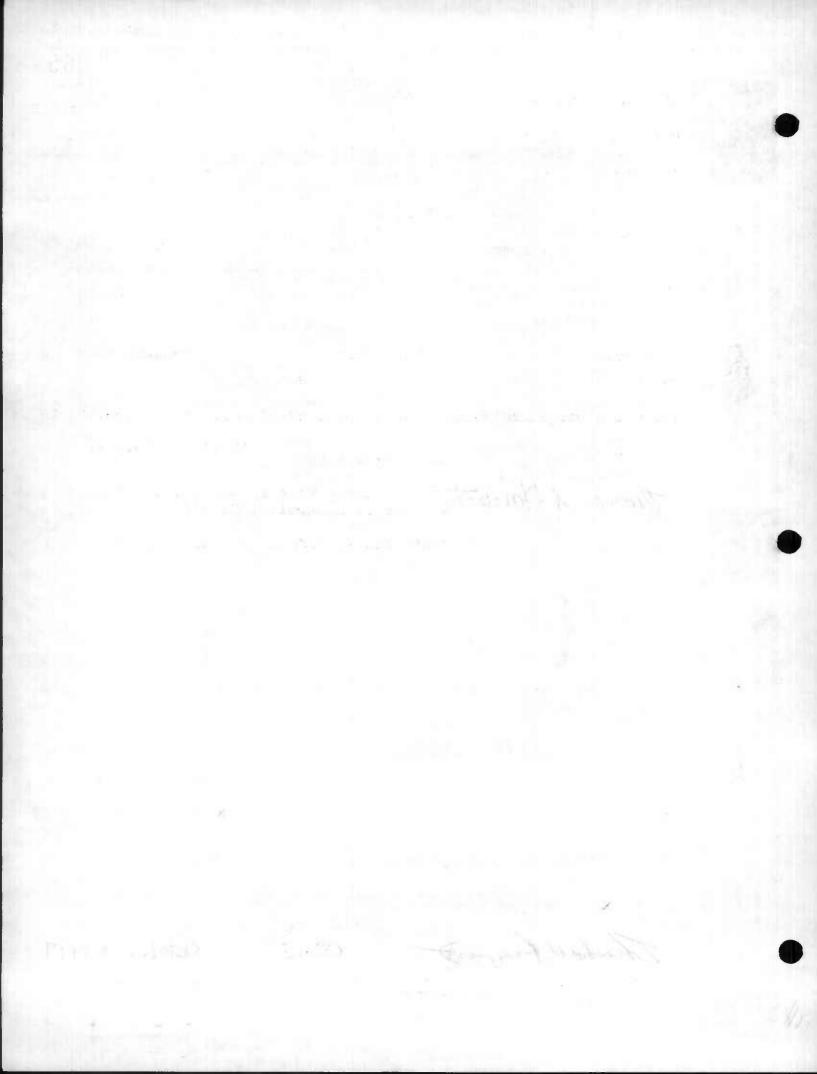
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/Medica		Ernest  4a. Fecility Name (If not institution, given		-46	-11	4h City Town or Los	ctobe	1	97 150M
Examine Funeral Director		Baltimore Reh 5. Social Security Number 218-26-6510		yrs. lest birt	hdey) If Under 1 Year Months Days		8. Dete of Birth (Month, Dey, 05-02	rear)	Death  A  B. Birthplace (State or Forei Country)  MD.
p 2		Usual Residence of Decedent  10a, State 10b, County	100	City Town	and anation				
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n 72 hours "natural",	ğ	15. Decedent's E (Specify only highest gre	ducetion	16a.	Decedent's Usual Occu, (Give kind of work done life. DO NOT use retire	pation		16b. Kind of Busin	
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Department Important: If any injury or pace.		21. Signature of Funeral Service Licer	**		22. Name and Addre	1			yland 2120
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ertific octor.	Ď	25. Wes cese referred to medicel examiner?	11			26. Place of Death	(Check only on	8)	
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the the	Cat	2 Accident investigation 3 Sulcide 6 Could not be	e con Cinco of Latino A	A b = = = - 4==		Yes 2 No	Of Leasting (Or		0
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12		30. Name and address of person who	completed ceuse of deeth (I	tem 23e) (1	ppe, Print)	VAMC 10	m 11/		1 BILLI
0111		31. Date flyor (Month, Dey, Year)	32. Registrar's Sig	nature	1 Palke	ا ماداده	01001	eche J	1341401114
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State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dev Tryqve Lohne 7 12;16 P Oct 1997 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Side 1220 West River Road Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthpiace (State or Foreign Country) **Funeral** Months Days 1 M 2□ F 88 Yrs. unknown Director May 25 1909 Norway Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Mexical Examiner must be notified entered. 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Md Anne Arundel Shady Side 1 ☐ Yes 🎾 🗌 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1220 West River Road 20764 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Biack, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 White 1 Yes 2 XNo Specify. þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4805 Woods Wharf Rd., Shady Side, Md 20764 Jacquelyn Douglass/Friend 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Balto., Md 20a. Method of Disposition 10/11 1 Buriai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Hardesty Funeral Home, P.A., 12 Ridgely Lomos Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, 300 as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Arteriosclerotic Cardiovascular Disease /Medicai immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner that the death certificate be executed physician and s the bunal-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting In deeth) Last Due to (or as a consequence of) P.O. Box 68760, an/Medical Due to (or as a consequenca of): signed by the attending the detached for use es Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed peeu has page 2 is certificate h 1 Yes 2 □ No 1 Types 2 No Division of Vital 25. Was case reterred to medical exeminer? Be 26. Piaca of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No funeral 28a. Date of tnjury (Month, Dey Year) 27. Manner of Death or Attending Planter death. 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Atterwithin 24 hours after des To the Funeral Director completely filled in by the 3 Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier 1 Cortifying Phystcian: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the ceuse(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the ceuse(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) October 8, 1997 us 30. Name and eddress of person who completed colors of death (Item 23e) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Md 21201 State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 7 30866 Item: 19a, per F.H. G-752 10/20/97 reb Certificate of Death 1. Decedeni's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Wild berser **Physician** Jeuni NNV 11:45 AW Oct /Medicai 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltiune 240 W. Marlyn AUZ Baltiun 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□ M 2 F Days 219252980 Baltrun (UD Yrs. Director 1 1986 Usual Residence of Decedent 10a. State WD 10b. County salvun 10c. City, Town or Location 10d. Inside City Limits Balliun 1 Yes 2 No Directo (Sistue as 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 240 USA 21221 Berns 23a Funeral Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married 8 2 No Specify: Whats þ 3 ☐ Widowed 4 ☐ Divorced Hygiene, Tratura Other than "natura ent, the Medical E Completed 15. Decedent's Education ify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dependant N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fl and Mental h Widher Dowy Cas pearam Saudra Jean 19a. Informant's Name (Relationship (Type, Print) Parents Mr. & Mrs. Douglas Wildberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Lip Code) Department of Health a Important: If Item 27 is any injury or other trau Douglas Wildberger 240 North Marlyn Avenue Essex, Maryland 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages Hilltop Service Corp. 10/11/1997 Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 100 medical property arrest, Approximately 100 medical property arrest, Approximately 100 medical property arrest, Approximately 100 medical property arrest, Approximately 100 medical property 100 medical prop Approximate thiervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ician end burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): SB for use Part It. Other significent conditions contributing to death but not resulting in the underlying cause given in Part to 23b. Did tobecco use contribute to the cause of death? 1 Yas 2 No Hurley sundvone 3 Probably 4 ☐ Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed disorder 24e. Was en eutopsy performed? page 2 recessive trait 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitai: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending efter death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 - Homicide • Funeral [

📈 CertifyIng Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

of death (ttem 23a) (Type, Print)

a Davidson-Randelle

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

State Registrar

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29a. Certifier

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Medical

**DHMH 16 Rev 6/95** 

Baltimore, Maryland 21215-0020

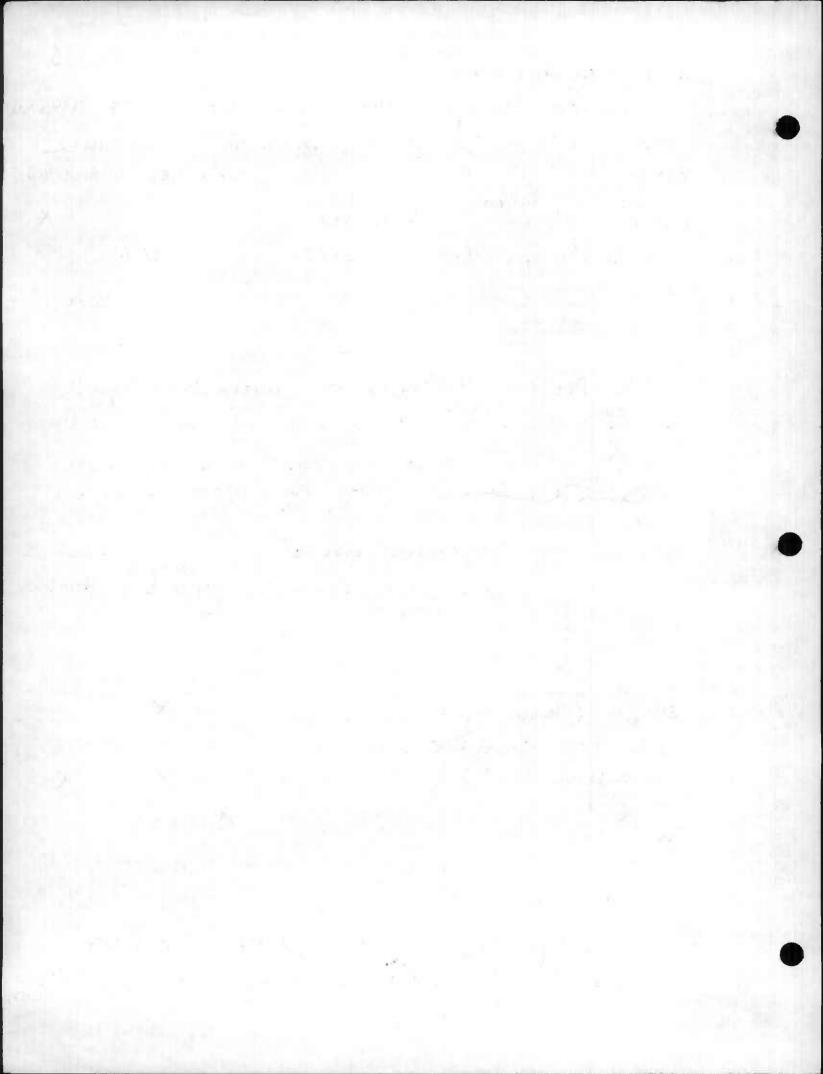
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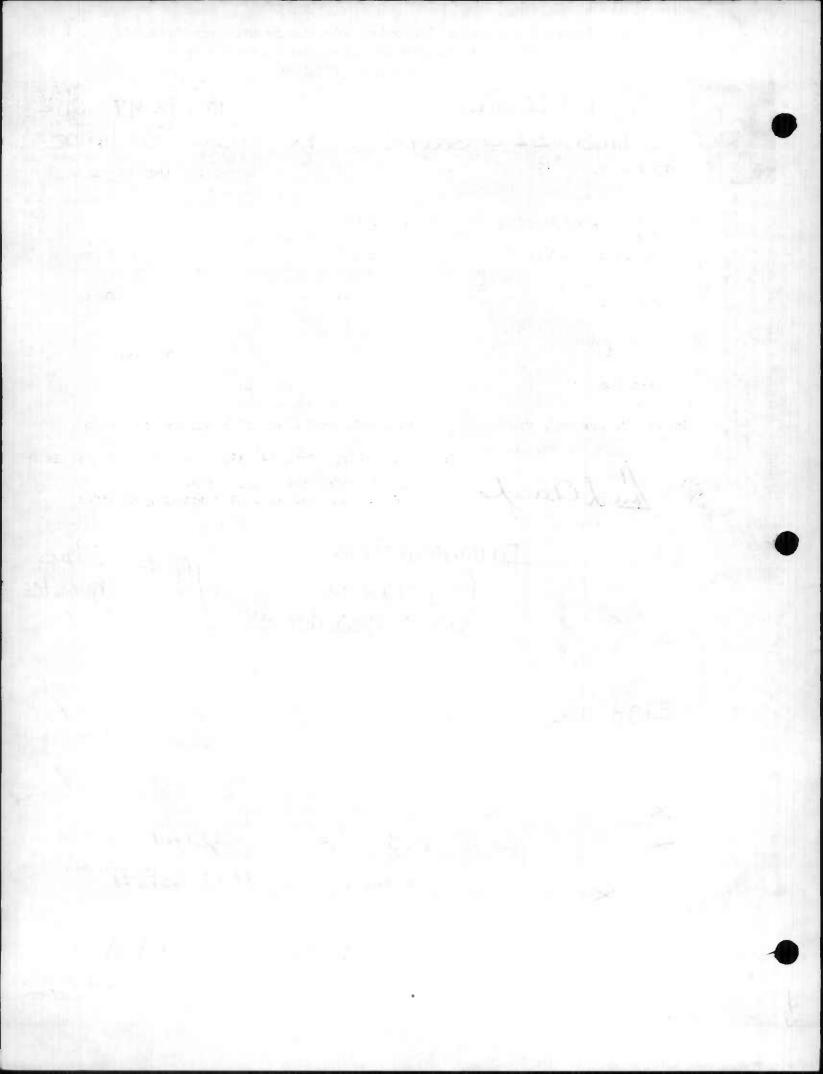
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State Registrar

ANURADAA ARUN, 31. Data flied (Month, Pay, Year)

30. Nama and address of person who complated ceuse of death (Item 23a) (Type, Print)

Dion MEMORIAL

32. Registrar's Signatura

Julia Savidson-Gandell UNION

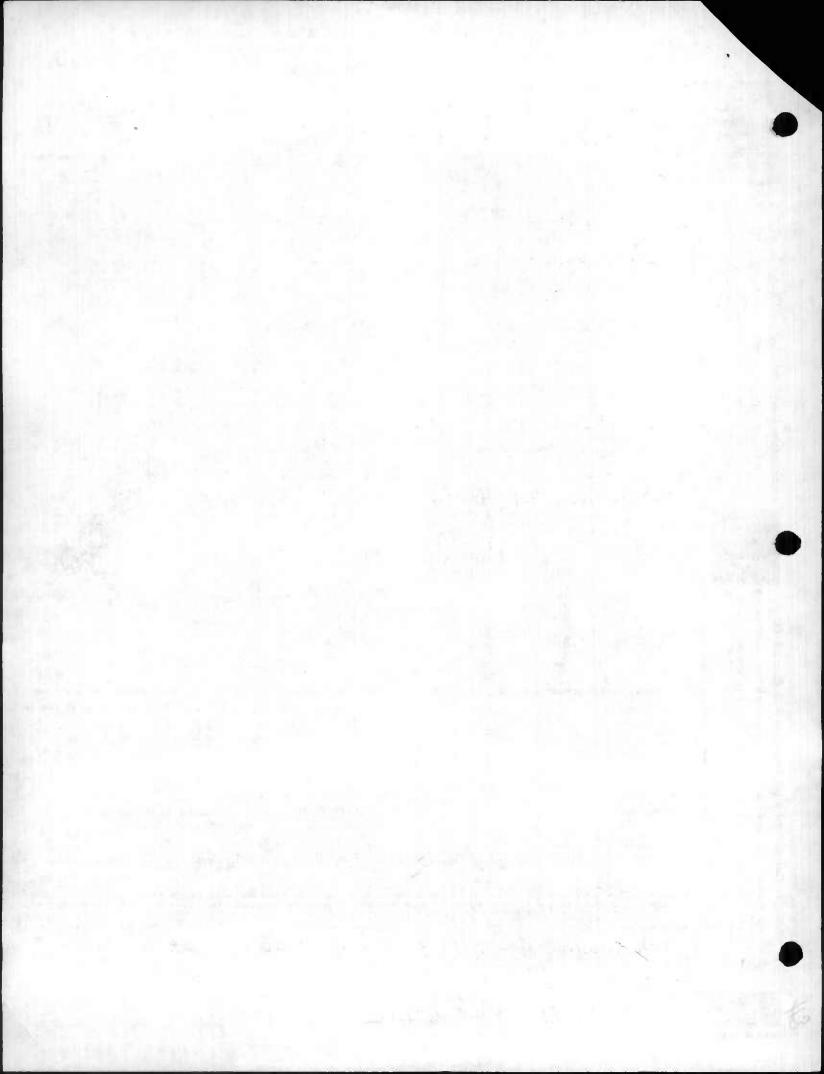
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UMPP 11840

HOSPITAL. BALTIMORE, MD

Oct 11, 1997.

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygien 6)

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1 0 0 TT	0	Lawrence Ray	Leeds					Kath	erin	e Fris	sch		
PEE		19e. Informent's Name/Reletions	ship (Type, Print)		19b. Me	iling Address (S	Street e	and Numbe	or Run	ai Route Numb	er, City or Tow	n, Stete, Zip	Code)
alth e 27 Is er trau		Mary M. Leeds	/ wife		12 1	Village	Roa	id i	Pike	sville.	Md.	21208	
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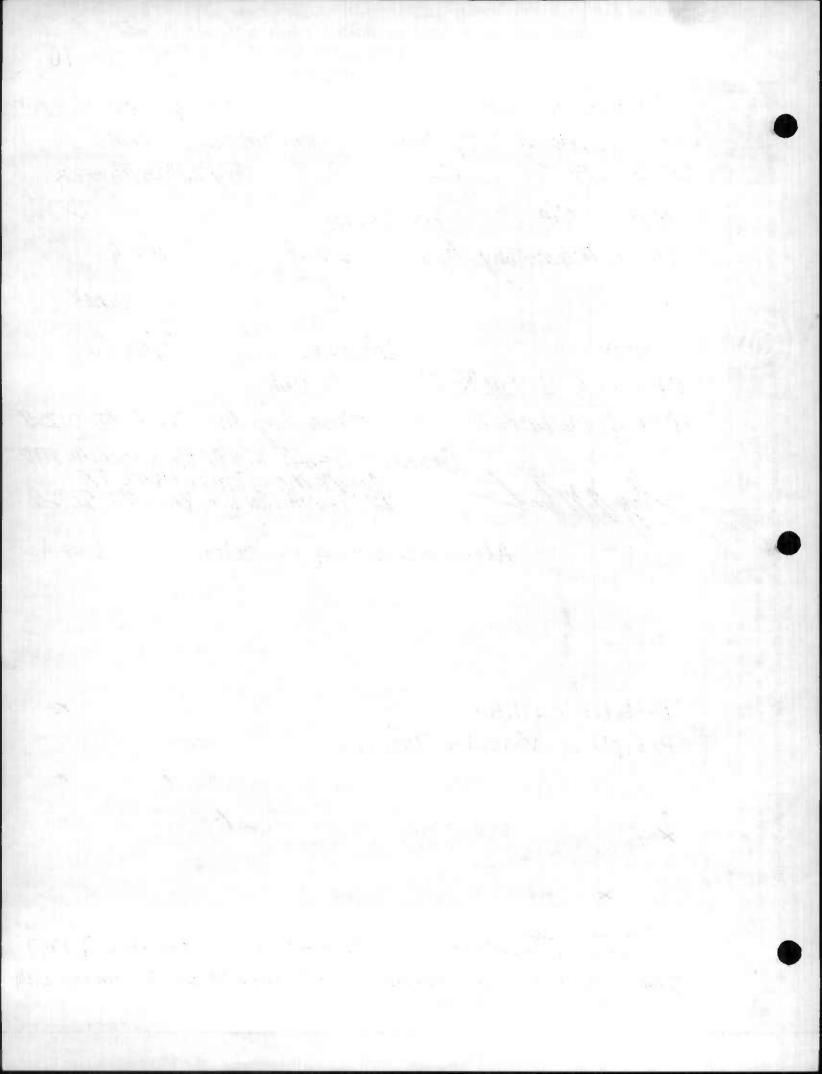
DHMH 16 Rsv 6/95

State Registrar

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State of Maryland / Department of Health and Mental Hygiene 97 30870

				Certificate of	of Death	R	eg. No.	00010
Physici /Medic		1. Decedant's Nama (First, Middle, Las GEORGE H	, LUCKE	TT		2. Dete of Deer Month	-	3. Tima of Death 12:447
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6	To Be Co	17. Father's Name (First, Middle, Last)	3. LUCKE	17		na (First, Middle, I	Maiden Sumame	))
Battimore, Mar permit. Pages 1 and 2 sh Department of Health and Important: if them 27 is an any injury or other traum once.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify  21. Signature of Funarel Service Licen	Removal from Stata	laca of Disposition (Name of emetery, cremetory or other)	PEST /	10/4/97 ( 14 TUSER	Durne Al Har	MIT, 21229 City or Town, Stata  15 Mills MT  15 F.A.,  17 71229
Physician /Medical Examiner	er	2.39 Path. Emp the disaate or comp or haan feilura. List only of Immediata Causa (Final disaase or condition resulting in daath)	. Adenoc	ARCI noma  rese e consequence of):			est,	Approximate Interval Batween Onset end Death  3 mon 465
O. Box 68760, he death cartificate be executed the attending physician and shed for use as the buriel-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	С.	r es a consequance of):				
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Vital Rec						1□ Y	as 2 No	1 ☐ Yes 2 No
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Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this cardificata has been signe completely filled in by the funeral director, page 2 should be completely filled.	Certification: T	27. Mengar of Death  Natural 5 Panding 2 Accident Invastigation 3 Suicida 6 Could not be	28a. Data of Injury (Month, Day Year) 28a. Place of Injury - At ho	28b. Tima of Injury M 1	☐ Yas 2 ☐ No	28d. Describe ho	reet and Numbe	
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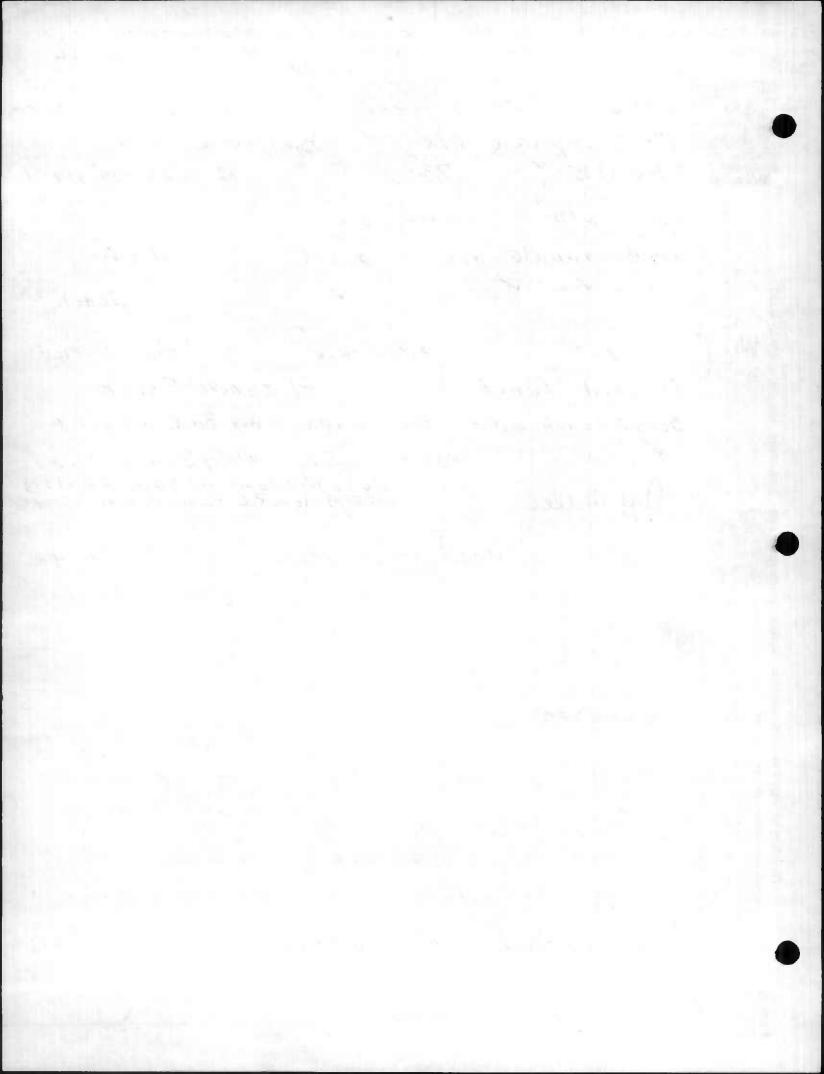
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State of Maryland / Department of Health and Mental Hygiene 7 30872

					Certifica	ate of	Death	R	eg. No.	00	
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ž.,	-	Usual Residence of Decedent  10a. Stete 10b. County	10	c. City, Towr	or Location						d. Inside City Limits
Sa-1 sho	ector	md. N/A		_	ti mor						1 Nes 2 No
23a or 28a-f should be notified at	Funeral Director	814 BONAPA	RTE AV	۷,	10f. 2	Zip Code	18	1	0g. Citizen of V	Met Counti	ry?
o. Ja	þ	11. Merital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Ves 2 No If Yes, Give Year or Dates:	in U,S.		cedent of hoecify Cub	lispanic Orlgin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		a - America ck, White, e	
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(41)	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	M	AIN TI	TNC	d) E		Pas	TO	2816.5
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ysician		23a. Pan . Enter the disease, or cor shock, or heart failure. List only	npilcations that caused the y one ceuse on each line.	death. Do r	ot enter the m	ode of dyli	ng, such as cardia	c or respiretory arm	est,		Approximate Interval Between Onset and Death
Medical aminer		Immediate Cause (Final disease or condition resulting in death)	a. Rec	tal	Con	cir	noma			C	he year
	ē	Tooland in Godin,	Due	to (or es e o	onsequence o					1	,
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h		30. Name and eddress of person who	ahmer, M	17	John	3 H	opkins	Hospita	al		



	State of Maryland / Department of Health and Mental	Hygiene 7	30
OSHUA ALAN MCALISTER	Certificate of Death	Reg. No.	00

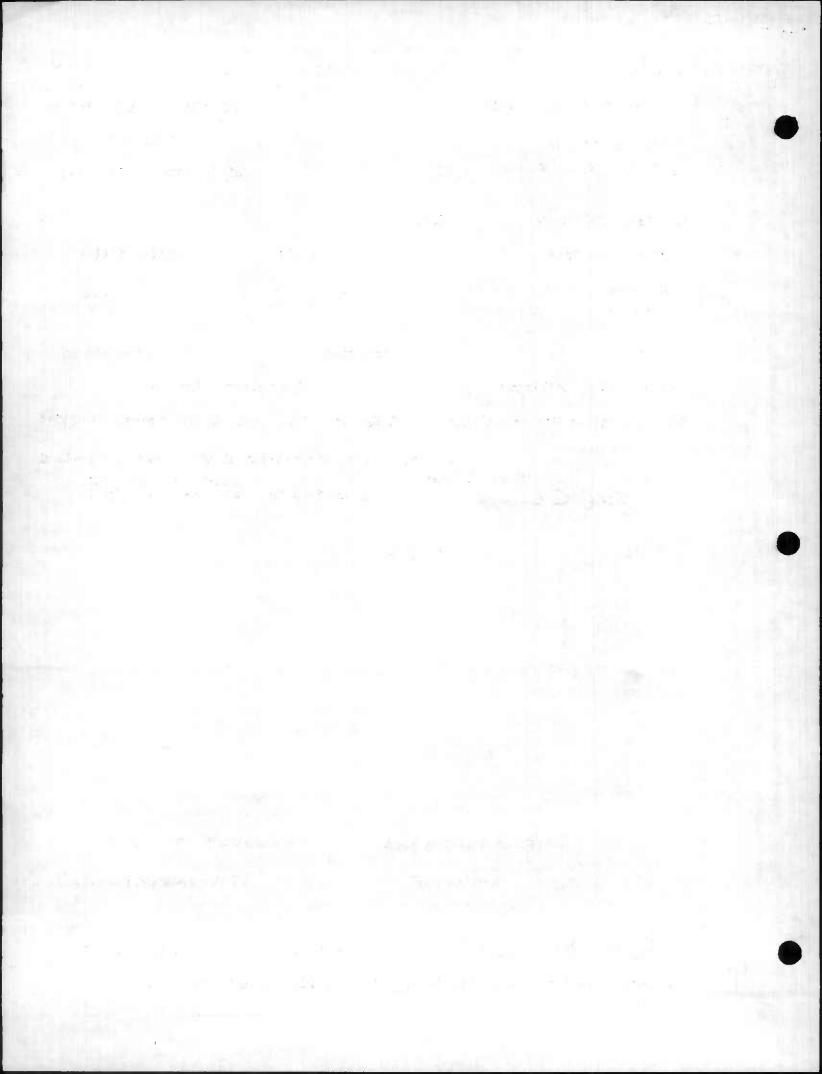
1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day Year SEPTEMBER 30 1997 **Physician** Joshua A. McAlister 7:15AM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **ESSEX** BALTIMORE #35 TERRACE ROAD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) 9. Birthplaca (State or Foreign **Funeral** Days Hours 100 M 20 F 216-17-2505 19 Yrs. Illinois July 26, 1978 Director Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 No Director Maryland Baltimore Essex 28a-f 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? b must be 21221 United States therms 23a 35 Terrace Road Funeral 12. Was Decedent Ever In U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marltal Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 X Never Merried 2 Married b Maryland 21215-0020 1 ☐ Yas 2 X No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced natural', Completed the Medical 15. Decedent's Education fy only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Spacify Elemantary/Secondary (0-12) College (1-4or 5+) Musician Self-employed 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middla, Maiden Surneme) and 2 should be and Mental marked Richard Earl McAlister Jacqueline Popiolek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, Stete, Zip Code) . Important: If Item 27 is any injury or other trac office. Health Mrs. Jacqueline McAlister/Mother 3100 Hamilton Ave., Apt. C, Baltimore, MD Baltimore, Pages 1 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State nant of 1 ☐ Burlal 2 X Cremation 3 ☐ Removel from State 4 Donation 5 Other (Specify) Hilltop Service Corporation 10/4/97 Towson, Maryland 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name end Address of Facility Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Md 21214 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Onset and Death **Physician** /Medica Immediata Causa (Final disease or condition rasulting in death) THERMAL BURNS Examiner Due to (or as a consequence of): Examiner certificate be executed Sequentially list conditions, if any, laading to Immediata ceuse. Entar Underlying Cause (Disease or Injury that Initiated evants resulting in death) Last Due to (or as a consequence of). Box 68760. Physician/Medical Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 2 1 Yes 2000 3 Probably 4 Unknown signed be del Records. 2 24b. Were sutopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? pege 2 s 1√ Yas 2 No 1 Ves 2□ No Vital director, Be 25. Was cese referred to medice! examiner? 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 X Yes 2 □ No Certification: To Division of this 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Dascribe how Injury occurred Hospital or Attending PP 24 hours after death.
 Funeral Director: After the letely filled in by the funeral 28c. Injury at Work? 5 Pending injury 1 Natural SELF THUDLANON FOUND 9 3097 0 705A M 1 Yas 2 No Investigation 2 Accident 6 Could not be determined 3 X Suicide 4 ☐ Homicida Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 35 TERRACE RD BALTHORE CO RESIDENCE To the Hospital within 24 hours a To the Funeral C completely filled 1 Cartifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) O.C.M.E. OCTOBER 01,1997

State

Registrar

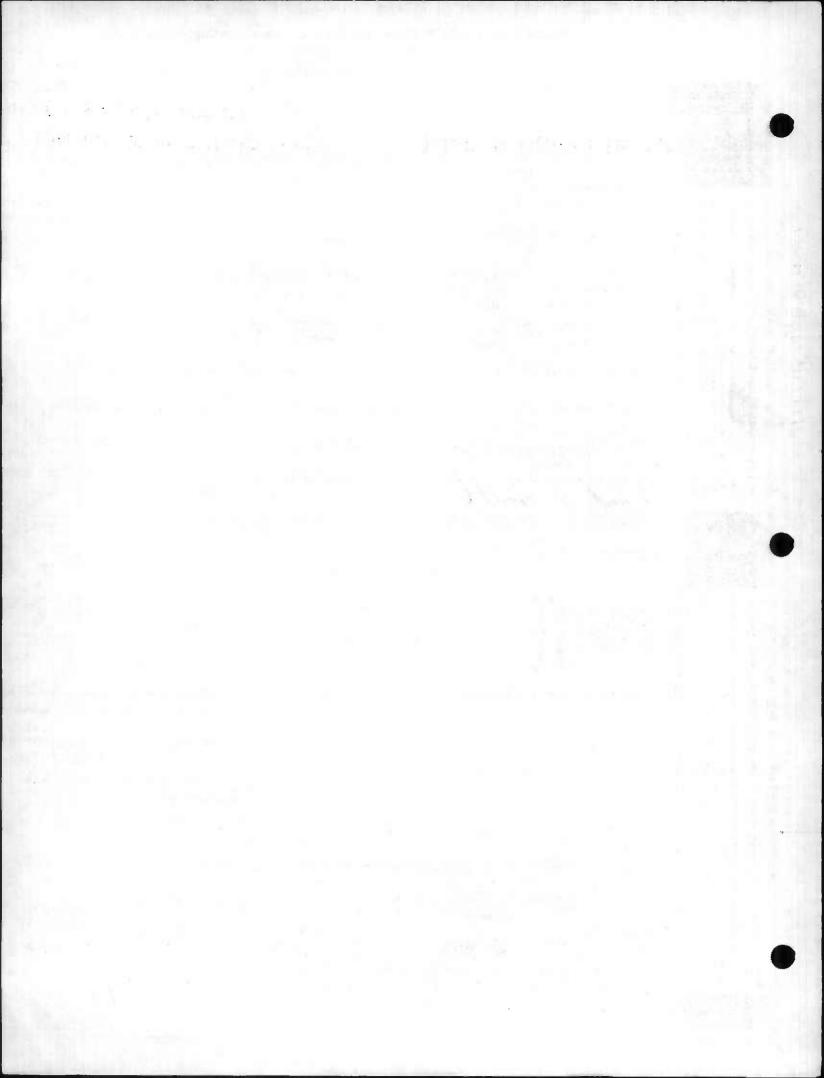
30. Nama and address of person who completed causa of daath (Itam 23a) (Typa, Print) . 111 Penn Street, Baltimore, Maryland 21201 Margarita Korell M.D.



# Mullen, Norman

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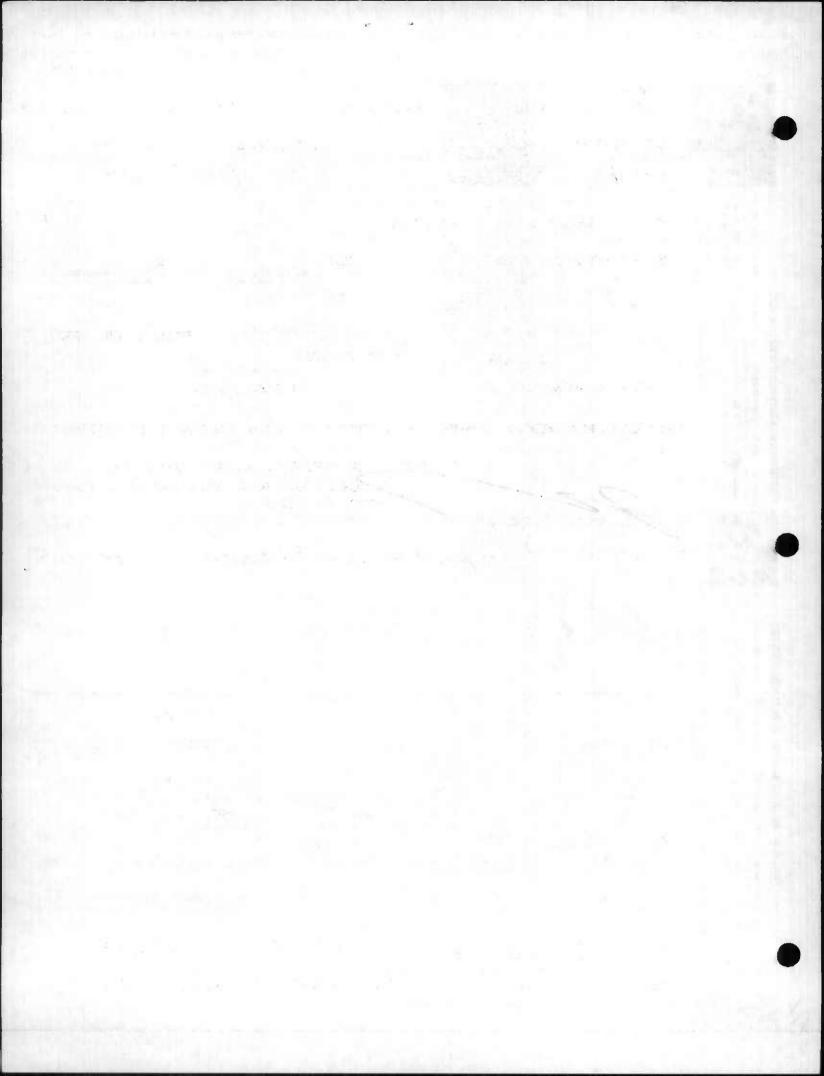


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician JOHN** OCTOBER 10, 1997 ROBERT MEADOWCROFT, III 11:30 A.M. /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8118 RIDGLEY OAK ROAD HILLENDALE BALTIMORE 5. Social Security Number If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 1/18/29 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Yrs. Director 218-16-1488 MARYLAND 68 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits ahow nam 27 is marked other than "natural", or itams 23a or 28a-f ahoo other traumatic avant, tra Medical Examiner must be notified at Director 1 ☐ Yes 2X No BALTIMORE HILLENDALE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8118 RIDGELY OAK ROAD death Funeral 21234 USA Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: KOREAN 1 Never Married 2♥ Married Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: p Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry FEDERAL GOV. (SSA) al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) TECH. MANAGER 2 YEARS permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is merked othe any Injury or other traumatic areas 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be JOHN R. MEADOWCROFT, JR. MILDRED SNYDER 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ANTOINETTE MEADOWCROFT WIFE 8118 RIDGELY OAK ROAD BALTIMORE, MD 21234 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY MEM. GAR. 10/14/97 COCKEYSVILLE, MD 21. Signeture of Funeral Service Licansee 22. Name and Address of Facility
JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. 21286 TOWSON, MD offer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical colorectal cancer Examiner Due to (or as a consequence of): Examiner buriel-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest and Due to (or as a consequence of): physician at the buriel Box 68760 Physician/Medical Due to (or as e consequence of): esn jo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. the 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy peeu certificate 1 ☐ Yes No 1 ☐ Yes 25 No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 25 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? After Natural 5 Pending efter deeth. Director: Aft 1 TYes 2 TNo Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide • Funeral Di Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) end menner es steted. completely (Check only one) 2 Madical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. within 2 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Solver Block, Baltimore, MD 21239 X Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygien 7 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month Day 1997 **Physician** Thomas Madden, Sr. October 8:20 A.M. /Medical 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, giva street and number) 4c. County of Death Examiner Baltimore 119D Versailles Circle Towson
If Under 1 Year | if Under 24 Hrs. 5. Sociel Sacurity Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthpleca (Stete or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours 212-05-3927 Yrs. Director Maryland Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits od 2 should be filled within 72 hours after death with the Manylan this and Mantal Hygleno.
77 Is marked other than "netural", or items 23s or 28s-f show transitic event, the Mantal Experies must be profilled as transmic event, the Mantal Experies. Baltimore Maryland Towson 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 119 D Versailles Circle 21204 U. S. A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yaa or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, atc. 1 □ Never Merried 2 □ Married 1 ☐ Yas 2 ☐ No If Yes, Give X 1 ☐ Yes 2 ☐ No Specify: by White ₩idowed 4 Divorcad Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Gas Meter Repairman B. G. E. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be John Thomas Madden Elizabeth Kennedy 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun 20b. Place of Disposition (Name of cametery, cremetory or other place)

20c. Location - City or Town, State MS. Mary Dolores O'Brien (DTR) Baltimore, 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stata 4 □ Donetton 5 Orbither (Specify) Entombment Dulaney Valley Mausoleum10-13-97 Timonium, Maryland 21. Signatura of Funaral Service Licensee 22. Name end Address of Fecility llace S. Brooks, In. Ruck Towson Funeral Home, Inc. 23a. Pert1. Enter the disaasa, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Betwe Onset and Death **Physiclan** PNEUMONIA /Medical Immadiete Ceuse (Final disease or condition resulting in death) 7 days Examiner Due to (or es e consequence of) Examiner physician and s the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Box 68760 Physician/Medical Due to (or as e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco usa contributa to the cause of death? Records, P.O. Atherosclerotic CArdo VAILLIAN disease 1 Yes 2 No 3 Probably 4 Unknown à 5-p Cerebro Macular Accident 24b. Were autopsy findings aveilable prior to completion of causa of deeth? 24e. Wes en autopsy performed? Completed peed has 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only goe) 70 Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled 12 Certifying Phyalcien: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) edical 29a. Certifier and menner steted. 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifiar 29c. License number D 1587/ M.D. 10/10/97 54 Scott ADAM RD COCKERSVIlle Med 21030 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) BOAS MD. LAWVENCE 31. Data filed (Month, Dey, Yeer) 32. Registrer's Signature State

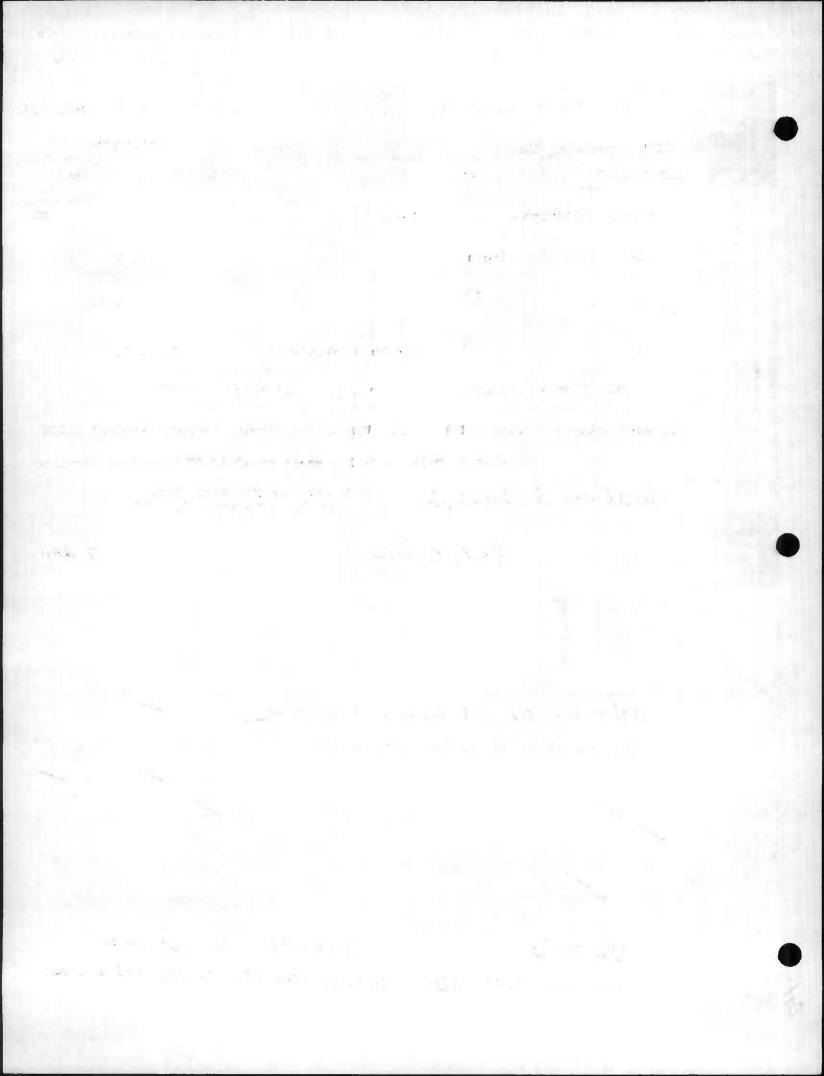
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State of Maryland / Department of Health and Maryland.

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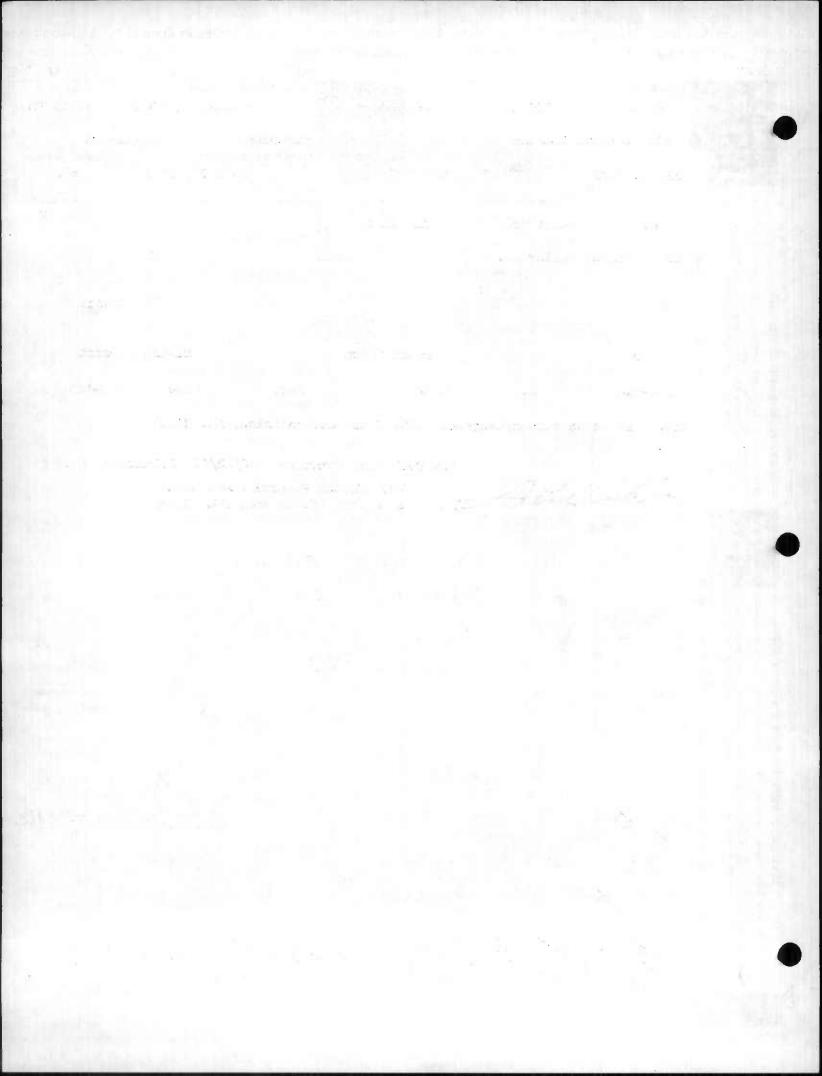
DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

		1. Decadant's Nama	(First, Middla	, Last)	- 1		tificate of		2. Data of Do		V	3. Tima of Dec
cia: dica	_	DOLORES		MARIE		MOELL			October	1		12:25
ine	er	4a. Facility Nama (If not institution, giva street and number)  4b. City, Town,						4b. City, Town, o	r Location of Deat			
al		5. Social Sacurity Nu	6. Sax	x 7. Aga (In yrs. last birthday) If Unde		If Undar 1 Yaar	If Undar 24 H					
r		212-03-34		1□ M 2፟፟ቚF	86	5 Yrs.	Months Days	Hours Mi	June 2	th ay, Year) 5, 1911	Coul	Md.
		Usual Rasidance of I	10b. County		10c. (	City, Town or Lo	cation				1	10d. Inside City Li
1	to	Md.	Ra	ltimore	imore Timonium							1 □ Yas 2 ₺
	irec	10e. Street and Num		TETHOLE		1 LINOII.	10f. Zip Coda			10g. Citizen of V	10g. Citizen of What Country?	
1	rai	2300 Dula	lley Rd.				21093		USA			
	by Funeral Director	11. Marital Status  1 □ Navar Married 2 □ Married  3 ☒ Widowad 4 □ Divorced		Armed I	12. Was Decedant Evar in U,S Armed Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas:		Vas Decedant of Hispanic Origin? (Sp Yas, specify Cuban, Maxicen, Puarto ☐ Yas 2 ☑ No Specify:		(Specify Yas or No arto Rican, atc.)	14. Race - American Indian Black, White, atc.  Specify: White		atc.
		(Snanit	s Education	ucetion 1 da complated)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of wo lifa. DO NOT use ratired)		nrkina	16b. Kind of Bu	16b. Kind of Businass/Industry		
	Be Compieted	Elamantary/Secon	1	(1-4or 5+)				TOTALLY		al al al al al al al al al al al al al a		
	S S	17. Fathar's Nama (F	ast)			Court Clerk		lama (First Middle		District Court Maidan Sumama)		
	0 8	Frederick	J.	V	aeth		Mary	4-9-1-1-1-1-1	Grace		Adams	
1		19a. Informant's Nar				19b. Mailin	g Addrass (Street		Rural Routa Numb	er, City or Town,	Stata, Zip	Coda)
ACTIVE.		Mrs. Suzar		ferson/				. Falls	ton, Md.			
		20a. Mathod of Disposition 1 ™ Bunial 2 □ Cramation 3 □ Ramoval from Stata						ce)	Data	20c. Location -	City or To	own, Stata
		4 □ Donation 5 21. Signatura of Fun			N		edral Cer		10/11/9	7 Balti	imore	, Md.
X		21. Signatura di Puli	eiai Saivio	00 PH			Nama and Addra CK TOWSO:		al Home,	Inc.		
	-	23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  1050 York Rd. Towson, Md. 21204  Approximate Interval Batween										
ı,	2				D09 10	(or es a conseq	uance of):	7-1110	are		1	
1000	dical Examiner	Sequentially list con- if any, leading to imi- cause. Enter Undart Causa (Disaase or in that initiated avants rasulting in daath) La		b	CC	(or as a conseq (or as a conseq (or as a conseq		FAIL	j			
100	edicai	that initiated avants		b. ————————————————————————————————————	Dua to	PD		CAO	j			
100	edicai	rasulting in death) La	ast	c	Dua to	(or as a consequence of the cons	uance of):	D				
Distriction of the state of	Physician/Medical	that initiated avants	ast	b c d	Dua to	(or as a consequence of the cons	uance of):	D	23b. Did	tobacco use co Yes 2⊡ No		
Dhoot alone	by Physician/Medical	rasulting in death) La	ast	cd	Dua to	(or as a consequence of the cons	uance of):	D	23b. Did		3 Pro	bably 4 Uni
Commission of the Physical Property of	Completed by Physician/Medical	Part II. Other signific	eant condition	d	Dua to	(or as a consequence of the cons	uance of):	Ovan in Part I.	23b. Did 1 12 24a. Wa: perf	Yes 2□ No s an autopsy ormed?  Yas 2 📉 No	3 Pro	dara autopsy findivallabla prior to
	be completed by Physician/Medical	rasulting in death) La	eant condition	Hospital:	Dua to  SE  death but not re	or as a consequence of the conse	p V	/an in Part I.  26. Place of D	23b. Did 1 1 24a. Wa: perf	Yes 2□ No s an autopsy ormed?  Yas 2 No ona)	3 Pro 24b. W av co of	lara autopsy find vallable prior to omplation of ceue death?
To Do Comment of the District of the State o	to be completed by Physician/Medical	Part II. Other signific  25. Was case refarre axaminar?  1 Yes 2  27. Manner of Death 1 Natural 2 Accidant	eant condition  id to medical  o  5 □ Panding Invastigi	Hospital: 1 L 28a. Dat	Dua to  SE  death but not re	(or as a consequence of the cons	uance of):  P V  Indextying causa give  a 3 DOA Ott  28c. Injury	/an in Part i.  26. Placa of Date: 4 □ Nursing	23b. Did 1 1 24a. Wa: perf 1 1 1	Yes 2□ No s an autopsy ormed?  Yas 2 No ona)	3 Pro  24b. W av co of	lara autopsy find vallable prior to omplation of ceue death?
Section of the sectio	Certification: 10 be completed by Physician/Medical	25. Was case refarre axaminar?  1 Yes 27. Wanner of Death 1 Accidant 3 Suicida 4 Homlcida	eant condition  and to medical  bo  5 □ Panding Invastigs 6 □ Could no	Hospital: 1 E 28a. Dat (Mc ation of be ned 28a. Plat buil	death but not read a of Injury anth, Day Year)  ce of Injury - At ding, alc. (Special contents)	or as a consequence of the conse	uance of):  P V  Indertying causa gh  28c. Injur  Wo 1  nat, factory, office	26. Place of Dear.  26. Place of Dear.  4 □ Nursing year k?  Yes 2 □ No	23b. Did 10 24a. Was perf 1	Yes 2 No s an autopsy ormed?  Yas 2 No ona) Idance 6 Oth how injury occur.  (Street and Number, Stata)	3 Pro  24b. W av co of 1 [ her (Special red	lara autopsy findivaliable prior to ompletion of ceus death?  Yas 2 No
Section of the sectio	Certification: 10 be completed by Physician/Medical	25. Was case refarre axaminar?  27. Manner of Death    Yes   20	eant condition  and to medical  bo  5   Panding Invastig  6   Could no datamin	Hospital: 1 E 28a. Dat (Mc ation of be led below)  Physician: To the xeminer: On tha	Dua to  SE  death but not re  a of Injury onth, Day Year)  ce of Injury - At ding, atc. (Spective Death Section 1)	or as a consequence of the conse	t 3 DOA Off  28c. Injur Wor 1 att, factory, office	26. Placa of Dar: 4 Nursing Yes 2 No	23b. Did 11 24a. Was perf 1	Yes 2 No s an autopsy ormed?  Yas 2 No ona) Idance 6 Oth how injury occur.  (Street and Numb. wm, Stata)	3 Pro  24b. W av occ of 1 [  her (Special red  ber or Rura  annar as s	lara autopsy findivaliable prior to ompletion of ceus death?  Yas 2 No
September 10 De Complete Discontinue de la Complete	legical Certification: 10 be completed by Physician/Medical	25. Was case refarre axaminar?  1 Yes  27. Manner of Death  29. Accidant  3 Suicida  4 Homicida	eant condition  and to medical  bo  5   Panding Invastige 6   Could no datamin  Certifying Medical E	Hospital: 1 E 28a. Dat (Mc ation of be led below)  Physician: To the xeminer: On tha	death but not read a of injury and injury and injury - At ding, atc. (Special contents)	or as a consequence of the conse	t 3 DOA Off  28c. Injur Wor 1 att, factory, office	26. Place of Dear: 4 Nursing Yes 2 No	23b. Did 11 24a. Wa: perf 1	Yes 2 No s an autopsy ormed?  Yas 2 No ona) Idance 6 Oth how injury occur.  (Street and Numb. wm, Stata)	24b. Wave coop of 1 [	lara autopsy findivaliable prior to ompletion of ceus death?  Yas 2 No  No.  No.  No.  No.  No.  No.  No.
September 10 De Complete Discontinue de la Complete	legical Certification: 10 be completed by Physician/Medical	25. Was case refarre axaminar?  1 Yes 2  27. Manner of Death 2 Accidant 3 Suicida 4 Homicida  29a. Cartiliar (Check only one)	eant condition  and to medical  bo  5   Panding Invastige 6   Could no datamin  Certifying Medical E	Hospital: 1 E 28a. Dat (Mc ation of be led below)  Physician: To the xeminer: On tha	Dua to  SE  death but not re  a of Injury onth, Day Year)  ce of Injury - At ding, atc. (Spective Death Section 1)	or as a consequence of the conse	at, factory, office	26. Place of Dear: 4 Nursing Yes 2 No	23b. Did 11 24a. Wa: perf 1	Yes 2 No s an autopsy ormed?  Yas 2 No ona) Idance 6 Oth how injury occur (Street and Numb wm, Stata)  causa(s) and madata and place,	24b. Wave coop of 1 [	lara autopsy find valiable prior to omplation of ceus death?  Yas 2 No  No. 140SP  al Routa Number stated. to the causa(s)
September 10 De Complete Discontinue de la Complete	Medical Certification: 10 be Completed by Physician/Medical	25. Was case refarre axaminar?  1 Yes 2  27. Manner of Death 2 Accidant 3 Suicida 4 Homicida  29a. Cartiliar (Check only one)	ant condition  and to medical  bo  5 Panding Invastige 6 Could nedatamin  Certifying Medical E	Hospital: 1 E 28a. Dat (Mc ation of be led below)  Physician: To the xeminer: On tha	Dua to  SE  death but not re  a of Injury onth, Day Year)  ce of Injury - At ding, atc. (Spective Death Section 1)	or as a consequence of the conse	t 3 DOA Oth  28c. Injun Wo  at, factory, office  occurred at tha tir astigation, in my c	26. Place of Dear: 4 Nursing Yes 2 No	23b. Did 11 24a. Wa: perf 1	Yes 2 No s an autopsy ormed?  Yas 2 No ona) Idance 6 Softh how injury occur.  (Street and Numb. wm, Stata)  causa(s) and madata and place, 29d. Data signe	24b. Way on of 11 and 1	deably 4 Un  Vara autopsy find valiable prior to omplation of ceut death?  Yas 2 No  No  No  Al Routa Number  stated. o tha causa(s)  Day, Yaar)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM#26 PER PHYNS FLM#G752 10/14/97 J.A. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** Month 3:30 A.M. October /Medical Town, or Location of Death 4a. Facility Nama (If not institution, give street and number) 4c. County of Daath **Examiner** pital saltimore Dinai If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1□M 200F Days 65 217-24-1522 Hd Yrs. Director -5 Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show must be notified at NA Baltimore 1 Yas 2 No Director Md 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò 4003 (grantley Items 23a Koad 21215 Funerai 12. Was Dacedanf Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amaricen Indian Black, Whita, atc. 1 Navar Marriad 2 Marriad Baltimore, Maryland 21215-0020 "natural", or 1 Yas 2 No Specify Specify: by 3 ☐ Widowad 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) Hygiene. Collaga (1-4or 5+) Entrepernu NA Str grude ner's Name (First, Middle, Liast) Dependent Peges 1 and 2 should be files.
Depertment of health end Mental Hygi Important: If Item 27 Is marked other eny Injury or other traument. 18, Mothar's Nama (First, Middle, Maiden Surnama) Mc Dowell 19a.,Informant's Name/Ralationship (Type, JIST W Bolto MD 21244 Location - City or Town, Stata 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, erematory or other 20c. Burial 2 Cramation 3 Ramoval from Stata 10-11-97 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensaa 4300 Grenue 23a. Part1. Enter the disease, or complications that coused the death. Do not enter shock, or heart failure. List only one cause on each line. tha mode of dying, such as cardiac or respiratory arrest, Intarval Batween Onsat and Death Physician Immadiata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner Saquantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last buriel-tran pue CO Pi Box 68760 Physician/Medicai the Dua to (or as a consaquanca of) attending for use as P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by t should be detech 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy completion of ceuse of death? Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funaral Director: After this certifica completely filled in by the funeral director; 25. Was casa rafarred to medical axaminar? 8 26. Placa of Daath (Chack only ona) Medical Certification: To 1 ☐ Yas 1 ☐ Inpatiant → ER/Outpatienf 3 ☐ DOA 28b. Tima of Injury 27. Mangar of Death 28d. Dascribe how Injury occurred 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datamined 3 ☐ SuicIda 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicida Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) 29b. Signatura, and titla of certifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number

State Registrar MH 16 Fev 6/95

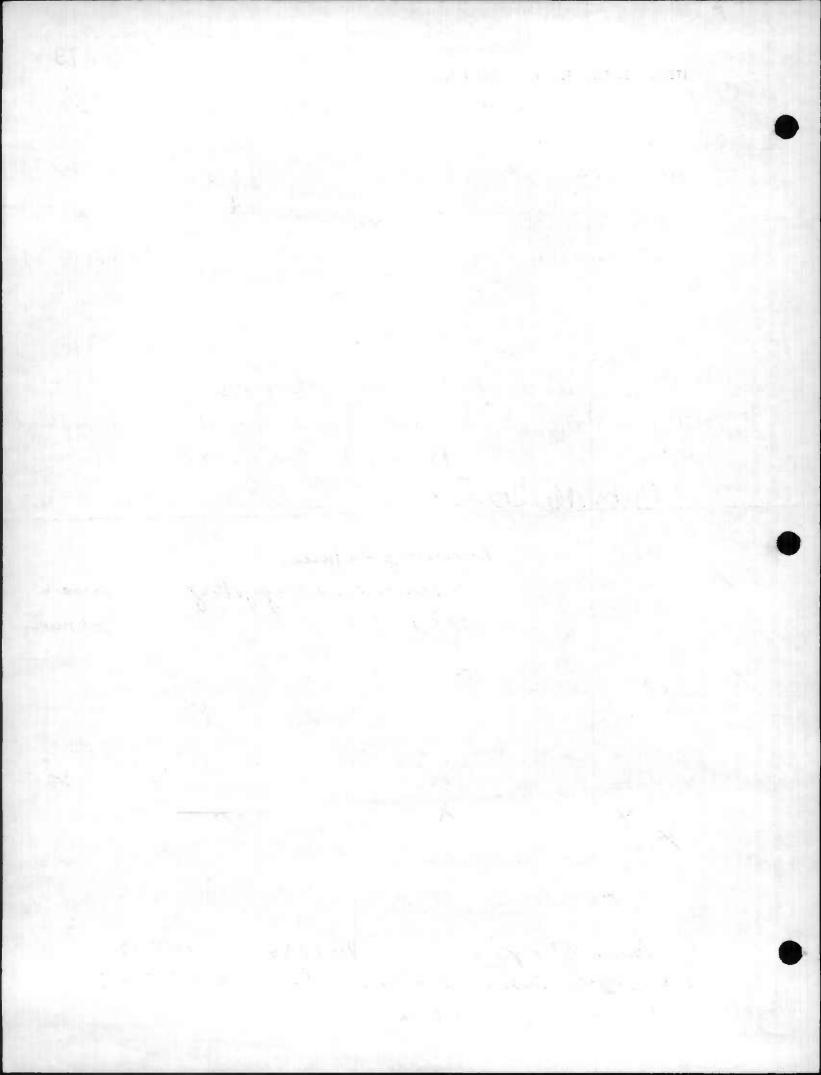
31. Data filed (Month, Day, Pear)
OCT 1 4 1997 141997

32. Ragistrar's Signatura wha Davidson

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

1435 W.

Be Wedere tue. Baltimore, MD 21215

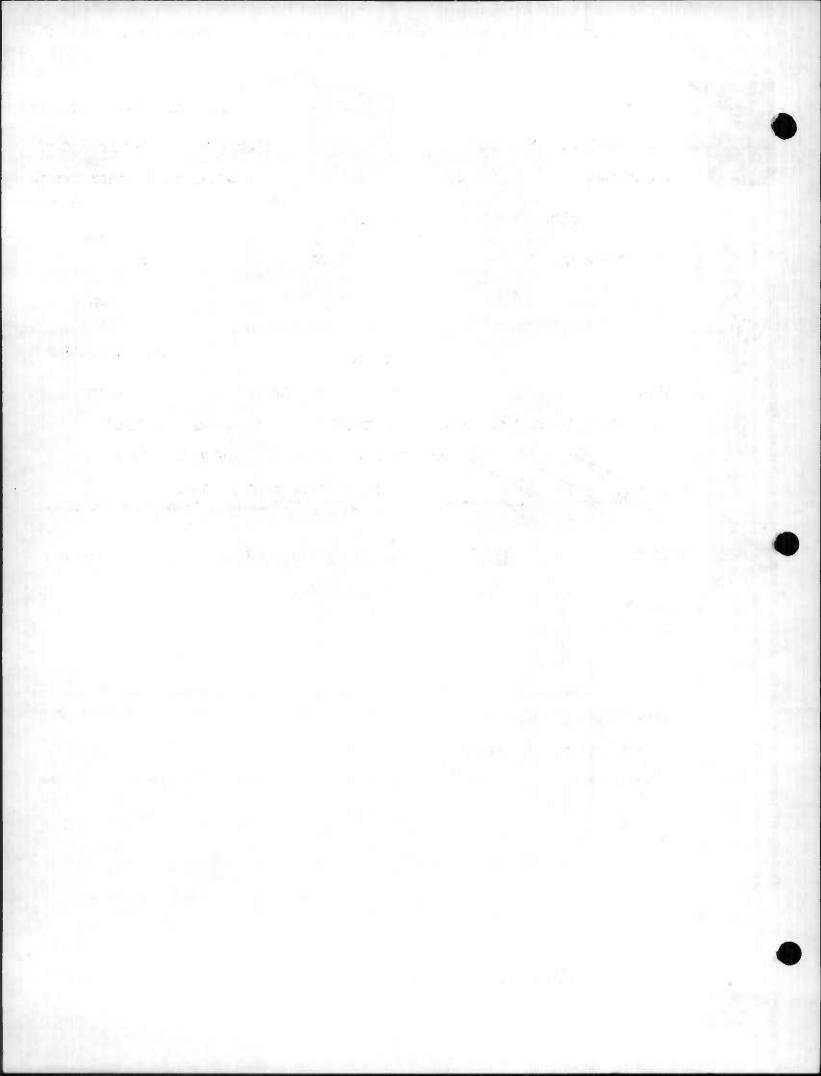


State of Maryland / Department of Health and Mental Hygiene

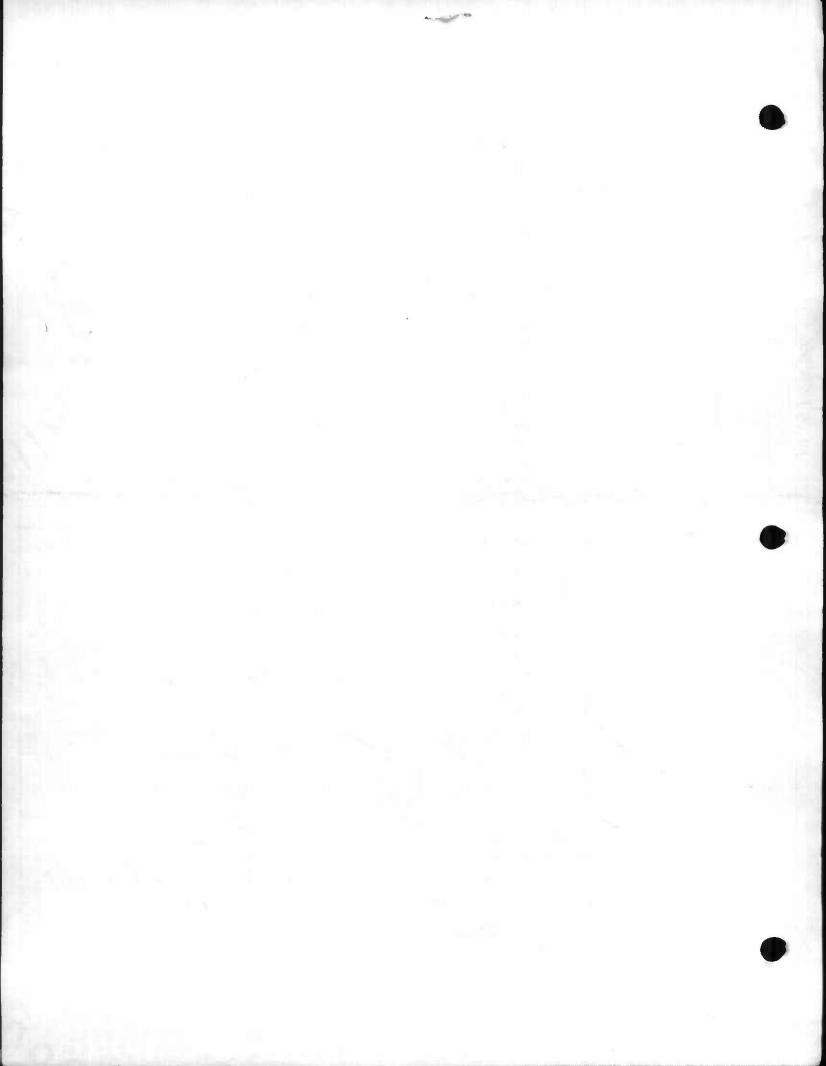
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** EDWARD **MYERS** OCT. 10 1:30 AM 1997 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE
If Under 1 Year If Under 24 Hrs. 8. Date of Bir
Months Deys Hours Min. 8. (Month. Da CATON MANOR NURSING HOME BALTIMORE CITY 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 15 M 2□ F Yrs. Director 164-16-6400 JAN 12,1920 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Herns 23a or 28a-f shortiner must be notified at 1 ☐ Yes 2√ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1031 REGINA DR. 21227 USA 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Sletus 1 Tyes 2 No If Yes, Give Year or Dales: 1 Never Married 2 Married Specify: 20 WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DEPT. OF HOUSING 12 CLERK 2 should be filed and Mental High Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be To LOUIS **MYERS** SARAH permit. Pages 1 and 2 st Department of Health and Important: if them 27 is m any injury or other traum 19a. Informani's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. ELAINE MARCUS (STEP-DAUG) 1031 REGINA DR. BALTIMORE, MD 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donellon 5 Other (Specify) MT. LEBANON -GEO. WASHINGTON 0/12/97 ADELPHI, MD 21. Signature of Editional Service Centre 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, o complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List on your ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Lew hrs Examiner Examiner many years iclan end burial-trans Sequentially list conditions, if any, leeding to immediate ceuse. Enler Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last physiclan s the burial Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, p 24b. Were autopsy findings available prior to completion of ceuse of deeth? Peptic ulcer Disease 24e. Was en eutopsy performed? Completed Depression 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: effer death. Director: After this certific 25. Was ceste referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled is 29a. Certifier (Check only one) 110 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es steted. 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 10, 1997 DQ 7541 Kaya MD 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)
GETHA RATA 4367 Holling Ferry
31. Date filled (Mgnth, Day-Year)
Julia Ballya scare signal and the state of the stat Rd, Baltmone MD Q12Q7 31 Date tiled (Month, Day Year)

**DHMH 16 Rev 6/95** 

Registrar



	1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM CERTIFICA			MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, ANNA, Last) MYRTLE	E. McKINNEY				2. DATE OF DEATH	MY YE	3. TIME OF DEATH	
	205 09 1925	1□ = 2#1 # 81	YRS. WOR		IF UNDER 24 HIBS. HOURIS MIN.	7. DATE OF BIRTH (Movin, One Mar) 5/4/16	PE	NNSYLVANIA	
TOR	MARINER NURNING		96.	GLEN	BURNIE	RNIE A.A. CO.			
DIRECTOR		A. CO.		WN OR LOCAT GLEN	BURNIE			10d. MISIDE CITY LIMITS? U YES 2 NO	
FUNERAL	378 KLAGG C	τ.		100	21061		F-12-20 12-17-17-17-17-17-17-17-17-17-17-17-17-17-	OF WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 □ Never Married 2 □ Warried 3 ∰ Wildowed 4 □ Diverced	2. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	# NO	If yes, ap-	ENDENT OF HISPA HITY, Cuben, Mexico 2 # NO Specif	NIC ORIGINT (Specify Yes, Puerto Ricen, etc.)	# or No 14. I	TACE - American Indian, Black, Writte, &FRO. AMERICAN	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co Elementary/Secondary (0-12)	FION 16a (1-4 or 5+)	(Give kind of work of the Do NOT use red	fone during mo red.)		166. KIND OF BU	HOME	TY.	
E COM	17. FATHER'S NAME (First, Middle, Last) CHARLES	FRANKLIN				AME (FIRE, ARRIVA, African ARL	CORUM		
TO BE	THE INFORMANT'S NAME (TypesPrint) GILLEN MCKINNEY	SON	196. MAILING ADD			Route Number, City or Tox	vn, State, Zip Code		
	204, METHOD OF DISPOSITION 1 ∰ Surfel 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	of from State 20b. PLA	CEANDDATE OF DE	DAY C	me of		OCATION — City of		
	21. SIGNATURE OF PUNERAL SERVICE LICEN	ester	185	ES 1	300 EUTA	HERS FUNER W PL. BALT	RAL HOME	P.A.	
CERTIFICATION	23. PART I. Enter the diseases, or conshock, or heart feliure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A COR  AN ONE TO (OR AS A COR  AN ONE TO (OR AS A COR  AN ONE COR  DUE TO (OR AS A COR  AN ONE COR  RECENSOR	NSEDUENCE OF:	dem	entro	L		Approximate interval Between Onset and Death Syeus. Seso Syeess Lyear.	
MEDICAL		pendent	chluse	this 1	cause given in Melli' A Ses e UNCERTAI	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO	
PHYSICIAN:		26. P OSPITAL:  Inpatient 2 ER/Outpatien		HER:	5 🗆 Residence	6 ☐ Other (Specify)			
BY PH	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME DF INJURY	28c. INJU	JRY AT	26d. DESCRIBE HOW	INJURY OCCURE	D	
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY A building, atc. (Specify)	t home, ferm, street	, factory, office		28f. LOCATION (Street City or Town, State	and Number or Ru	rel Route Number,	
COMPLETED		IN: To the best of my knowledge On the basis of examination and						se(s) and menner es stated,	
BE	296. SIGNATURE AND TITLE OF CERTIFIER	ee			29c. LICENSE NUI	MBER 73	29d. DATE SIG	NED (Month, Day, Year) 7 <sup>(H)</sup> 1997	
5	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETEO CAUSE OF DEATH	(ITEM 27) (Type, Print,	Mar	ylad	21081			
	31. DATE FINED (MONITY, Day, 18-07) 31. 14 1997	37. REGISTRAPS SIGNATURE	Holable						



Maryland

N/A

USA

Specify:

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

1 YES 2 NO

White

21244

21133

Interval Between

Onset and Death

Approximate

10:45

funeral director, page 5 should be detached for use as the burial-transit

Ħ

notified

be

must

examiner

the medical

event,

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

25. WAS CASE REFERRED TO MEDICAL

5 Pending

6 Could not be

1 YES 2 NO

27. MANNER OF DEATH

1 Natural

2 Accident

3 Sulcide

4 Homicide

(Check or one)

and completely filled in by the oburtal, cremation, or removal.

hours after

Pages 1, 2, 3 should

permit.

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

	E	E	5	2
	4	ely	nati	- On
0	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the
DIVISION OF VITAL RECORDS, P.O. BOX 68760	P	mo	ul, c	3
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH Cubbin 04 8. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR | IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year HOURS 1 M 2 X F 216-14-0227 June 8, 9a, FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Wesley Home Baltimore 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Baltimore Rockdale 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8320 Liberty Rd 21244 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 ☐ YES 2 ☒ NO Specify: 1 Never Married 2 Married 3 🔀 Widowed 4 🗌 Divorced 16e. DECEDENT'S USUAL OCCUPATION

The blad of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Hutzlers Elementary/Secondary (0-12) College (1-4 or 5+) 9 years 0 Sales Department Store 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Walter Harding Frizzell Emma M. Frey 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Aural Route Number, City or Town, State, Zip Code) Baltimore, MD Harding D. McCubbin (Son) 8320 Liberty Rd. 20a. METHOD OF DISPOSITION
1 ◯ Buriel 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) Freedom Cemetery 10 - 11New Freedom, PA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 23. PARE/I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finei disease or condition CARDIOVAS CULAR Peuth resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Advanced AGE Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF)that initiated events reaulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. hio Acute Respectory Farline, hio 9 I blead 1 TYES 10 Atrial felulatur

N AUTOPSY PRMED? 2 KNO	24b. WERE AUTOPSY FINDING AMRIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	1 TYES 2 TV/NO

Inpatient 2 - ER/Outpatient	3 DOA	4 Nu	rsing Home 8 🗌 Residence	6 Other (Specify)
26a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF URY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED

M 1 YES 2 NO	
street, factory, offica	261. LOCATION (Street and Number or Rural Route Number City or Town, State)

R 1	X	CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and menner as stated.

26. PLACE OF DEATH (Check only one)

MEDICAL EXAMINER: On the basis of exemination and/or investigation	in my opinion, death occured at the time, data end place, and due to the cause(a) and menner as stated

	The state of the s	ca, and due to the cause(a) and market as stated.
96. SIGNATURE AND TITLE OF CERTIFIER  R. JULIA, WS.	29c. LICENSE NUMBER  Da 1 4 6 Y	29d. DATE SIGNED (Month, Day, Year)  10-8-97
A MAME AND ANDRESS OF REPROMINING COMMITTEES CALLED AN ACCOUNT		

O. NAME AND AD	DRESS OF PERSON WI	O COMPLETED CAUSE	OF DEATH (ITEM 27) (Type.	Print)

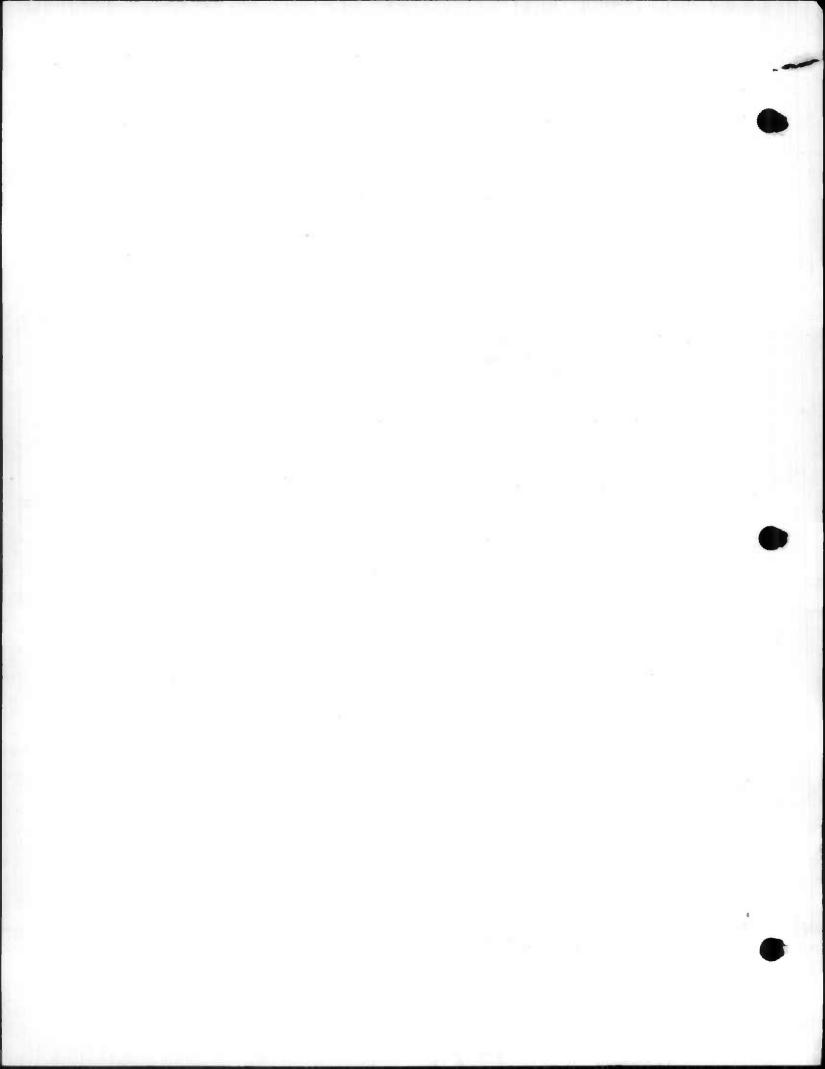
HOSPITAL:

ROBERT LIBERTY,		3508	BMh	5+	21224
OCT 1 4 1997	Julia David	SIGNATURE Box-Randal	2		

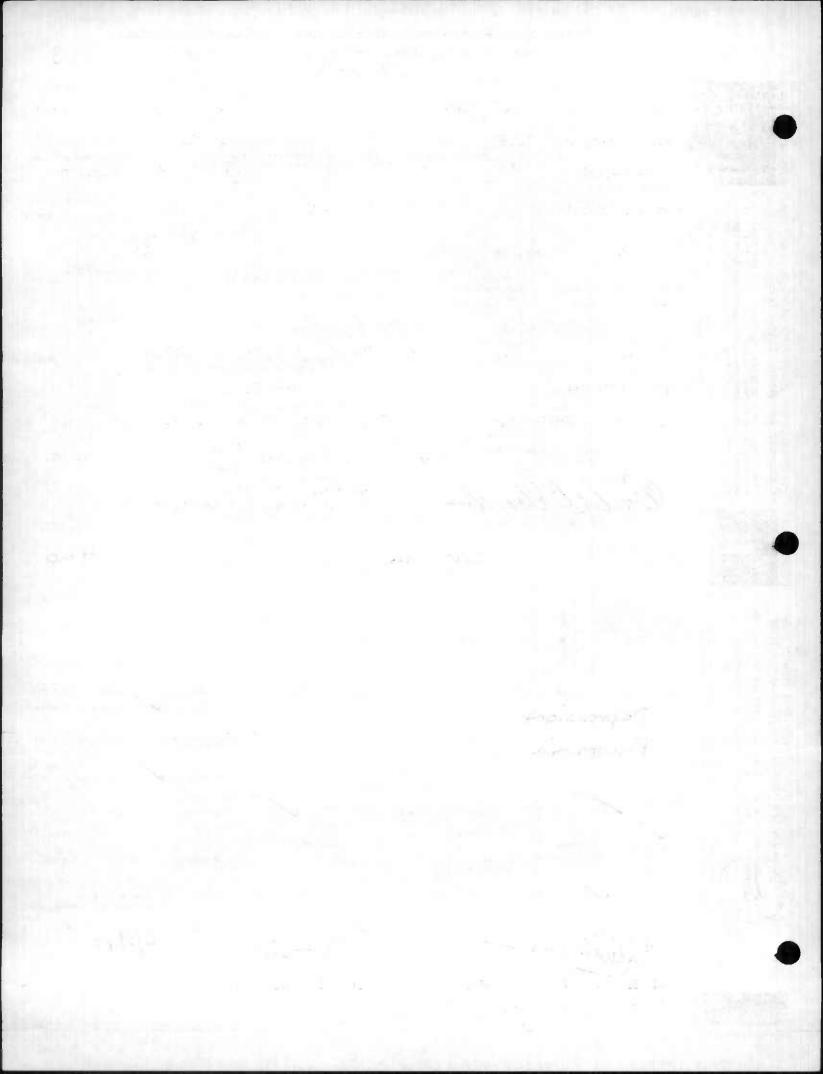
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

28s. PLACE OF INJURY — At home, ferm, building, atc. (Specify)

6



		Decedant's Nama (First, Middla, i	anti		C	ertifica	ite of	Death	2. Data of	Reg. No.		3. Tima of Death
nysician Medical		DOROTHY H.	MULLH					th City Town	Month OCT	. 7, 199	Yaar 7 y of Death	9:40PM
kaminer		MANOR CARE- RO		561)					nore Cou			e County
neral		212-03-8166	Sax 7 1□ M 2⊠ F	Aga (In yrs.	last birthda Yrs.	y) If Und Month	ar 1 Yaar s Days	If Undar 24 H Hours M		Birth Day Year] 3, 1914	9. Birthp Coun Ma	laca <i>(Stata or Forei</i> try) Tyland
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i Directo		10e. Street and Number 4012 Putty Hil	l Avenue				Zip Coda	21236		10g. Citizan of		1 □ Yas 🏋 N
It of Health and Mentel Hygiene.  If Item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumstic event, the Medical Examiner must be notified at or other traumstic event, the Medical Examiner must be notified at		11. Marital Status  1 □ Navar Marriad 2 □ Married  3 ◯ Nordidowed 4 □ Divorced	12. Was Deced Armed Ford 1 Yas 2 If Yas, Giva Yaar or Dat	as?	J,S. 13	If Yas, sp	edant of Hoecify Cubs	ispanic Origin? an, Maxicen, Pu Specify:	(Specify Yas or arto Ricen, atc.)	No- 14. Ra Bis	ce - Amaricack, Whita,	
eted		15. Dacedant's Educetion (Specify only highast grada complated)			18a. Dac	edant's Us	ual Occup	ation during most of v	rorking	16b. Kind of I		
omo		Elemantary/Secondery (0-12) 8 yrs.	College (1-4 N/A	lor 5+)		-		rant Owr		Self-E	mploy	ed
To Be C	3	17. Fathar's Nama (First, Middla, La: Howard Hilditc			,				ama (First, Midd E. Vaet	dia, Meidan Sume :h	me)	
		19a. Informant's Name/Ralationship								nber, City or Town		Code)
ouce.	2	Lawrence J. Mu  20a. Method of Disposition  1 Burial 2 Cramation 3	☐Ramoval from St	ata	Place of Dis	position (A	lema of r othar plac		Date 10-11	e, Md. 2]	- City or To	wn, Stata
once.		4 Donation 5 Dothar (Space 21. Signature of Funeral Septice Lic		/		22. Nama	and Addra	ss of Facility Funeral	1997	06	IT CTIIIO	ie, mu.
an caller Examiner		23a. Part1. Enter the disease, or co ahock, or heart failure. List on Immediata Causa (Final disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Causa (Disease or Injury that initiated avants	y ona causa on aad	SAC Due to (		aquance o	f):	g, such as cerd	lac or raspirator	y arrest,		Approximate Intraval Batween Onsat and Death  4 Mo
Physician/Medicai		Causa (Disaasa or Injury that initiated avants rasulting in death) Last	c		or as a cons			an in Part I.				o the cause of deat
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Completed		Preumon	a	51 A					pe	es an autopsy enformed?	ave con of	ara autopsy finding: allabla prior to mplation of causa death?
o Be Com		25. Was cese rafarrad to medicel axaminar?						26. Pleca of D	eeth (Check on			Yas 2□ No
- I		1 Yas 2 No 27. Menne of Death 1 Watural 5 Pending	Hospital: 1 🗆 Inp 28a. Date of (Month,		28b. Tima Injury	of	28c. Injur Wor	4 Ly Nursing		asidance 8 🗆 O		y)
Certification:		2 Accident investigati 3 Suicide 6 Could not determine	be 28a. Place o	f Injury - At h ), atc. <i>(Speci</i>	oma, farm,			143 2 140		n (Straet end Num Town, Stata)	ber or Rura	l Routa Number,
edical		29a. Certifiar (Check only one)	hyalcian: To the barniner: On the bas	is of axamina	owladga, da ation and/or	ath occurre invastigation	d at tha tir on, In my o	na, data and pla pinlon, daath oc	ce, and dua to t curred at tha tim	ha causa(s) end n na, data and place	nanner as st	teted. tha cause(s)
Me Me		29b. Signatura and title of certifier	161			2	9c. Licans	a numbar 4460	4	29d. Data sign	ad (Month,	Day, Yaar)
1	3	MICHAEL DAVID SUTO	complated ceusa N 8100 HAR				TIMODE	, MARYLAI	ID 21224			

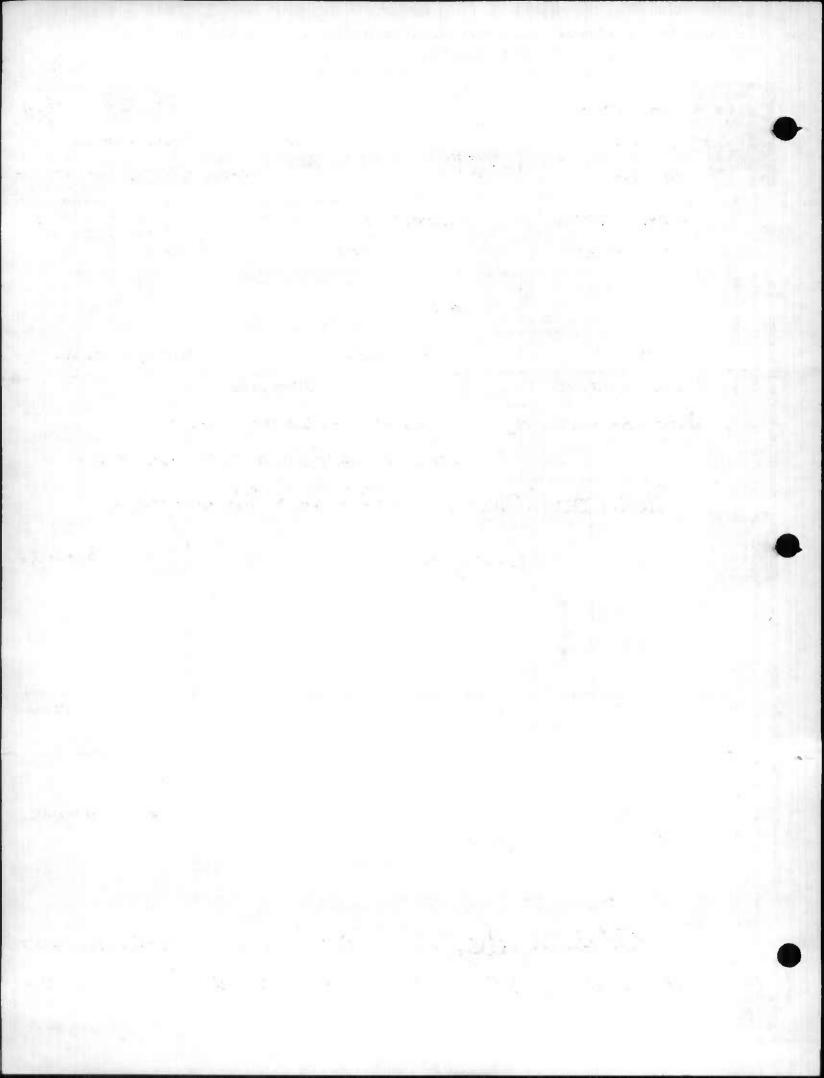


State of Maryland / Department of Health and Mental Hygiene

30884 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** John C. McPherson III UCTOBER /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Gildhrist Center Baltimore County Towson If Undar 1 Yaar if Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Data of Birth (Month, Day, Year) Birthpiaca (State or Foreign Country) **Funeral** 1□ M 2□ F Yrs 217-16-1646 Ocotber 9, 1923 **Director** 74 Letohatchee, Alabama Usuai Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11406 Manor Road 21057 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ⊠ Yas 2 □ No If Yes, Give Yaar or Dates: WW ∐ Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 ☐ No Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "n any Injury or other treumatic event, for Mean Sonce. College (1-4or 5+) N/A Elementary/Secondery (0-12) Owner Operator Community Ice Co. Inc. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maldan Sumama) Webster B. McPherson Lillian Askew 2 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) John C. McPherson IV (Son) 6100 Belair Road Baltimore, Maryland 21206 20b. Place of Disposition (Nama of cematary, cramatory or othar place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns. October 15,1997 Timonium, Maryland 21. Signature of Funeral Service Licensas 22. Nama and Address of Facility Lassahn Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that earsad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. 7401 belair Road Baltimore, Maryland 21236-4625 **Physician** immediata Cause (Final disease or condition resulting in death) /Medical 3 months ung cancer Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): for use es signed by the e Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: director Be 25. Was case refarred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? After 5 Pending Investigation 1 Natural 2 Accident s after de. None 1 Yes 2 No 6 Could not be determined 3 Suicide 281. Location (Streat and Number or Rural Route Number, City or Town, Stata) Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 24 hours aft Funeral Di letely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely within 2 To the F 29d. Date signed, (Month, Day, Year) 29b. Signature and title of cepifier 29c. Licansa number 30. Neme and address of persop who completed cause of teath (Item 23a) (Type, Print) N. Charles St. Bolto. MJ. 21208 GBMC 6701 132. Registrar's Signatura

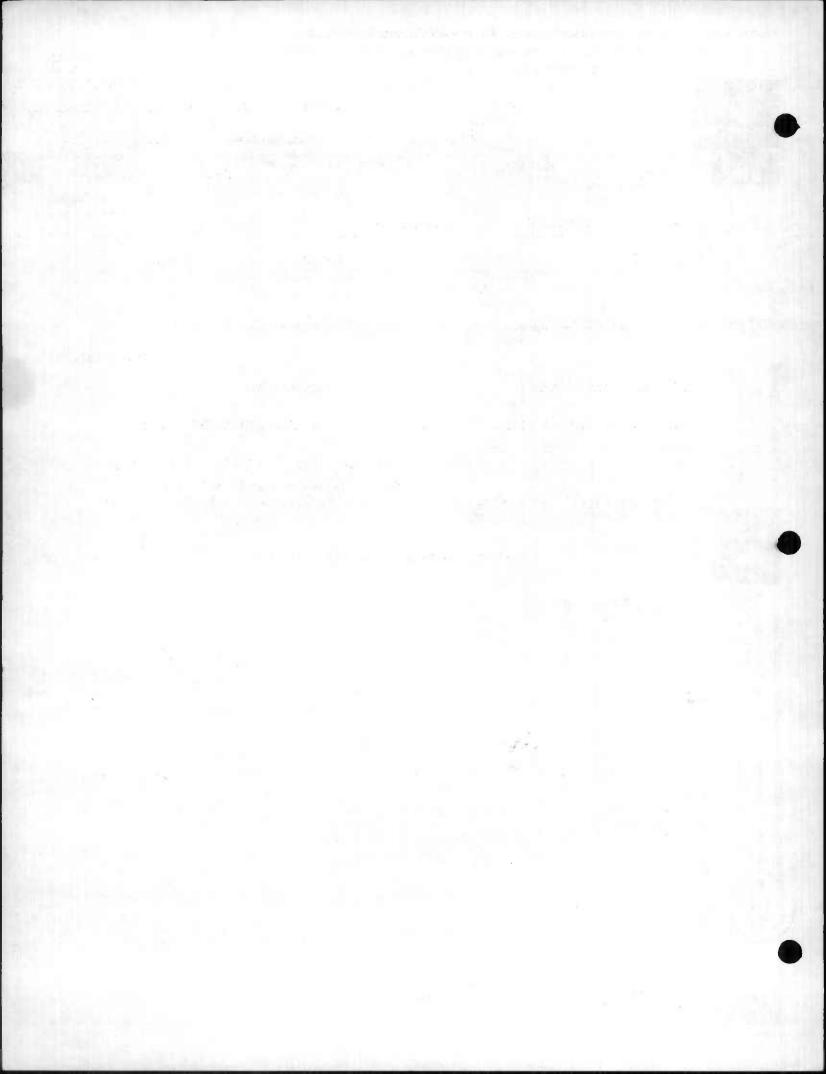
State Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

Physicia	an	1. Decedent's Nama (F	First, Middle, La.				34	ACON	2. Data of Dec Month	Day	Year	3. Time of De
Medic	_			CARL			M	ASON		er 29,1		2:49 I
xamin	er	4a. Facility Nama (If no			er) .			4b. City, Town, or				
-		Memorial  5. Social Sacurity Number	-		Ann the une	last birthday)	If Under 1 Yea	Cumber		Alle		
neral ector		236-28-56 Usual Residence of De	524	M 2□ F	76	Yrs.	Months Days		8. Date of Birt (Month, Da 12-1-		VV Sinthp	laca (Stata or Fo try)
det	_	10a. Stata 10	b. County		10c. Ci	ty, Town or Lo	cation				1	0d. Inside City L
offfie	Director	WV	BERKE	LEY	GE	RRARDS'	1					1 Yes 2
frems 23s or 28s-f show frem must be notified at	급	10e. Street and Numbe	er .				10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
n 23	era	ROUTE 1 11. Marital Status		12. Was Decede	ot Ever le 1	IS 12 W		420	nacify Van av Na	U.S.A.	a - Americ	an Indian
"naturel", or then od cal Examiner	by Funeral	1 Nevar Married	2□ Married	Armed Force 1  Yes 2] If Yes, Give	s? ] No		Yas, specify Cul	Hispanic Origin? (S ban, Maxican, Puert Specify:	o Rican, etc.)	Blac	k, White,	
al E	D D	X	. Decedent's Ed	Yaar or Date	S:	16a Dagad	lentia I level Occ	unation.		40h Kind of D	WHI	
	Completed	(Specify o	only highest gra	de completed)		(Give i	lent's Usual Occu kind of work done OO NOT usa retin	during most of wor	rking	16b. Kind of Bu	JSINess/Inc	lustry
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othe /ent,	BeC	17. Father's Name (Firs	st, Middla, Last)		1/2	DRIVE	Λ	18. Mother's Nar	ne (First, Middle,	COMMERC ] Malden Sumam	AL T	KUCK(S)
	ToB	CHARLES WII	LLIAM MA	ASON				CLARA MA	SON			
raumatic		19e. informant's Name	/Relationship (7	Type, Print)		19b. Mallin	g Address (Stree	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code)
or tra		BETTY L. K	ITCHEN/	DAUGHTER		RT. 1	BOX 36.	GERRARDS	TOWN. W	25420	)	
rother		20a. Method of Disposi	tion			Piaca of Dispos	sition (Name of natory or other pla		Date	20c. Location -		wn, State
ary or		1 X Burlal 2 C 4 Donation 5			10				10/2/07	MARTTMC	RIIRC	7.77.7
Important: If any injury or once.		21. Signature of Funeral Service Licensea  22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821,									W_V	
E = 8		Jan O	w-M	Moura				G ST., MA			25/00	
g physician and es the burief-transit	Examiner	Sequentially list conditi if any, leading to imme cause. Enter Underlyin Cause (Disease or inju	ions, diate	b	Due to (	or as a consequ	uenca of):					
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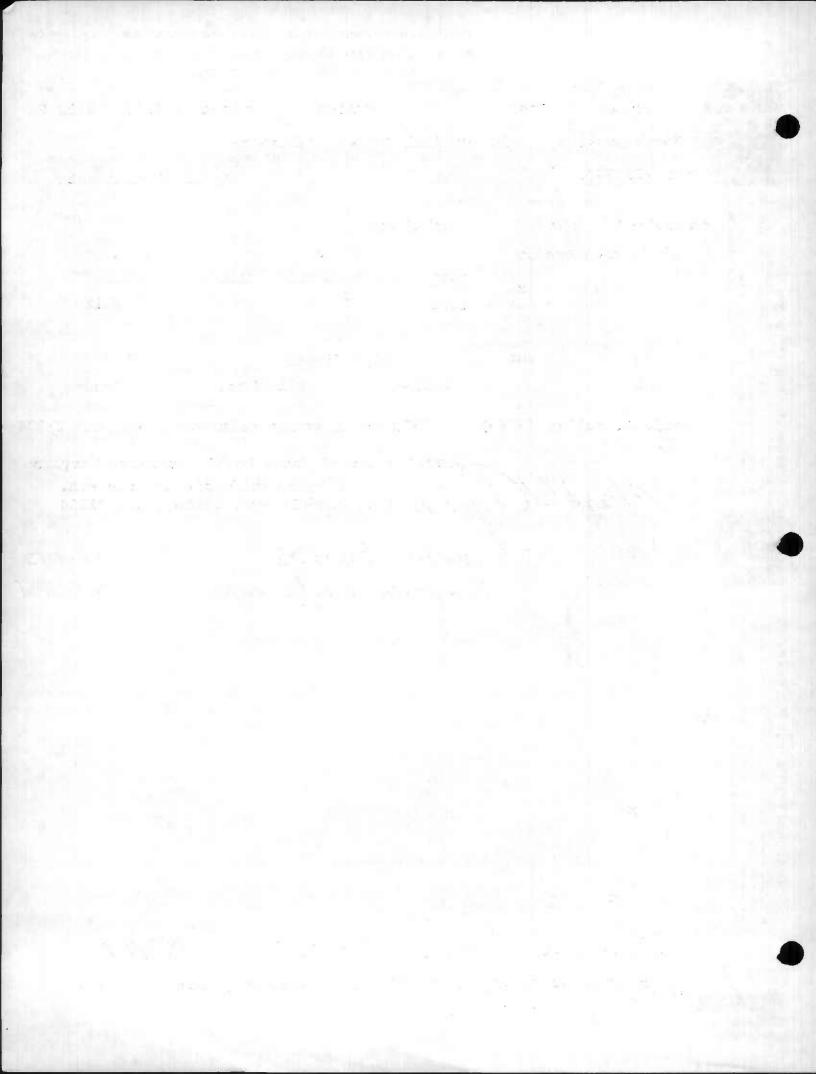
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 7 30886

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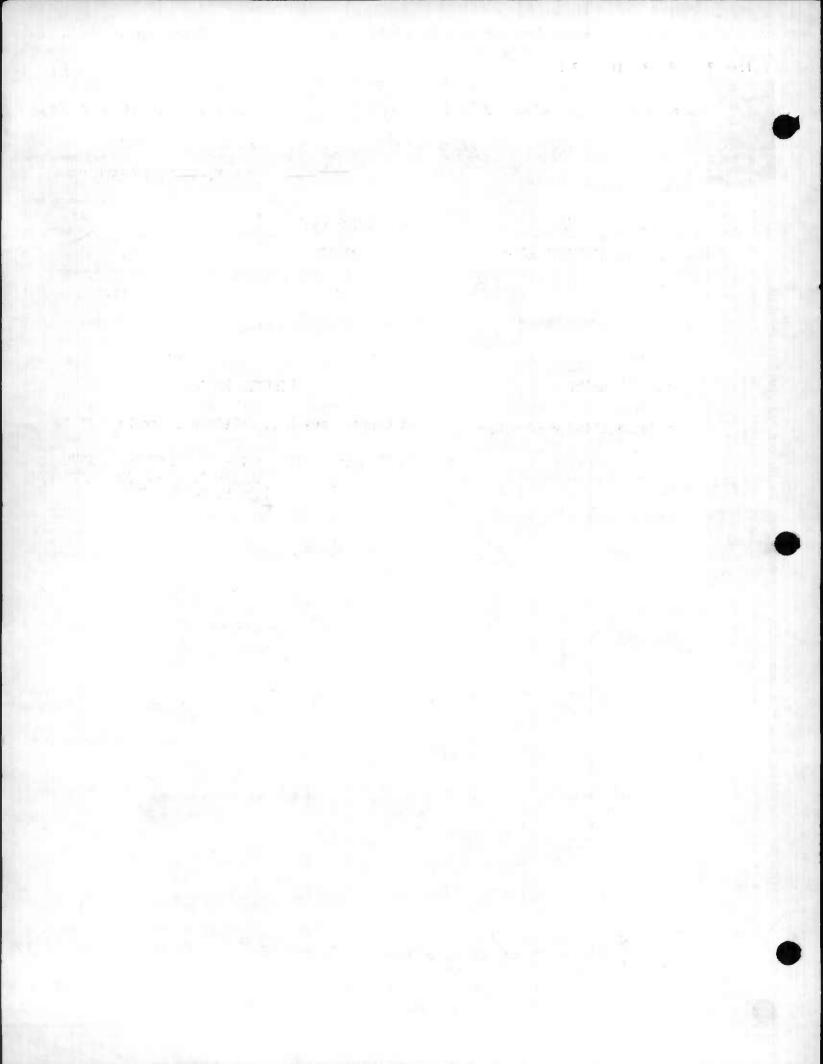
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Item #7 per FH G753 11/25/97 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Year Month **Physician** GIRL OCTOBER 10, 1997

ocation of Deeth 4c. County of Death 1997 /Medical 4e. Fecility Neme (If not institution, give street and number 4b. City, Town, or Location of Deeth Examiner 1+05PITA L Age (In yrs. last birthdey) II Under 1 Year Months Days BALTIMORE CITY

If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Y THE JOHNS HOPKINS 7. Age (In yrs. last birthdey) 5. Sociel Security Number 9. Birthplece (State or Foreign **Funeral** 10 M 30 F Director -1997 MARYLAND Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or itams 23a or 28a-f show traumstic event, the Medical Examinar must be notified at XXYes 2 No Directo MARYLAND N/A BALTIMORE CITY 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 701 BENNINGHAUS ROAD 21212 U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes #XXNo If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. filed within 72 hours after Never Merried 2 Merried Baltimore, Maryland 21215-0020 Specify: BLACK 1 ☐ Yes 2 💢 No Specify: p 3 Widowed 4 Divorcad Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other treumatic event, Tra Medions. Elementary/Secondery (0-12) College (1-4or 5+) 0 years none none 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) TEFRELL BRADY LINETTA PRESCOE 19e. informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 701 Benninghaus Rd., Baltimore, Maryland 21212 Mamie Macklin/Grandmother 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1) (Cyclinat 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) WESTERN STAR CEMETERY 10-14 BALTIMORE, MARYLAND 21. Signeture of Funeral Service Licanses 22. Name end Address of Fecility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Physician/Medical thet initiated events resulting in deeth) Last Due to (or es e consequence of) use as Po signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes an eutopsy performed? Completed page 2 has 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient 10 1 Yes 2 INO 2 ER/Outpatient 3 DOA funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28c. Injury et Work? 28d. Describe how injury occurred Certification: Division 1 Naturet 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end menner es stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pteca, end due to the cause(s) end menner steted. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Julia Day doon - Handale 3 GANDA 600 W. WO180 STREET, Battiman, pro 27287-3200 31, Date filed (Month, Dey, Year) State 141997 Registrar



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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ian		YREE	PEOPLE	S				Month OCTOBER	Day	Yeer	1943PM
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	UNIVERSITY SHOCK	TRAUMA	UNIT			BA	LTIMORE	CITY	N	I/A	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Month October 9,1997 Glenda Marie Page 2:12AM 4e. Fecility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Daath 4c. County of Death University Hospital Baltimore 8. Data of Birth (Month, Dey, Year) Birthplaca (Stata or Foreign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 1 M 2 X F 35 Yrs. 147-62-5991 April 1,1962 south Carolina Usual Rasidance of Dacedant 10c. City, Town or Location 10b. County 10d. Inside City Limits Yas 2 No Maryland N/a Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 209 #C Atholgate Lane 21229 USA 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 11 Meritel Stetus 1 Nevar Married 2 Married 1 ☐ Yas 2 ☒ No If Yes, Give 1 ☐ Yas 2 No Specify: Specify: Black 3 Widowad 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12th N/A Product Inspector C. D. S. Inc. 17. Fether's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) James A. Page Eula M. Johnson 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Eula Page-mother 49 elmhurst Ave., Trenton, New Jersey 08618 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata October M☐ Burial 2 ☐ Cramation 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Other (Specify) 14,1997 Ewing township, N.j. Ewing Cemetery 22. Nama and Addrass of Facility Douglass Funeral Services 1701 Me Culloh Street, Baltimore, MD 21217 23a Part Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Immadiata Causa (Final diseasa or condition rasulting in death) Multiple Injunies Dua to (or as a consequence of): Dua to (or as a consequence of): Due to (or es e consequance of)

**Physician** /Medical Examiner

physician i the burla

Box 68760

Division of Vital Records, P.O.

**Physician** 

/Medicai

Examilner

10a. Stata

Director

Funerai

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Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at

filed within Hygiane.

permit. Pagas 1 and 2 should be fit.
Department of Haatth and Mental Hy
Important: If item 27 is marked othe

3altimore, Maryland 21215-0020

Examine Physician/Medical þ Completed

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to complation of causa of daath?

26. Placa of Death (Check only ona)

1 Yas 2 No

25. Was casa rafarrad to medical axaminar? 1 Yas 2 No 27. Mannar of Death

Hospital: 2☐ ER/Outpatlent 3☐ DOA 28a. Data of Injury (Month, Day Year) 5 Panding 10-9-97 Invastigation 6 Could not be datarmined

28b. Tima of Injury 0212 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

Street

28c. Injury at Work? 1 Yas 2. No

Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 28d. Dascribe how Injury occurred

Automobile Accident 28f. Location (Street and Number or Rural Route Number City or Town, Stata) Frederick Read Baltimore City, Maryland

29a. Cartifier

1 Natural

3 ☐ Sulcida

2. Accidant

4 Homloida

29c. Licensa number

1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stafed.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Data signad (Month, Day, Year)

29b. Signeture end titla of certifier

O.C.M.E.

OCTOBER 9, 1997

30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

Radentz, MP 111 Penn Street, Baltimore, Maryland 21201 Stephen

31. Dete filed (Month, Day, Year) State Registrar

10

Certification:

Medical

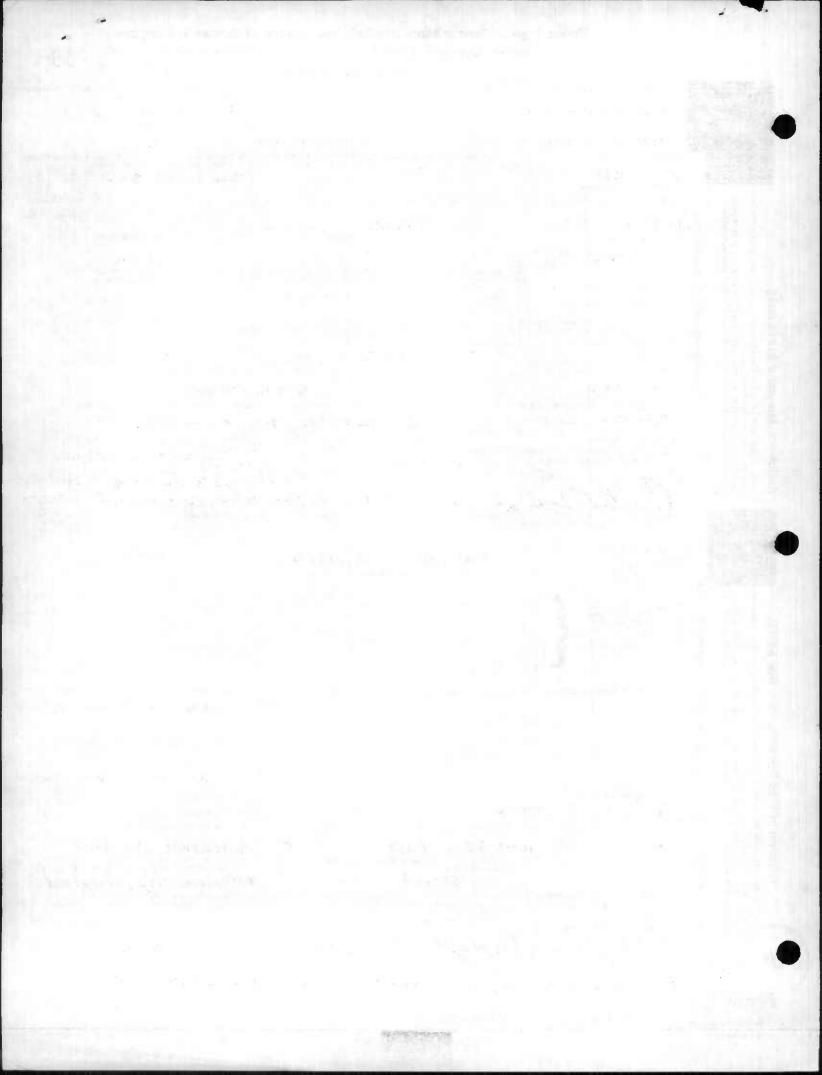
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24 hours after of

the Hospital Illnin 24 hours a to the Funeral C

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32. Registrar's Signatura hella Davidson-Randall



Certificate of Death

WILLIAM P. RAMSEY

State of Maryland / Department of Health and Mental Hygiene

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of Deeth	Day	V	201		3. Ti	me	of D

Physiciar /Medica	
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10d. Inside City Limits

Approximete Interval Between Onset end Deeth

1 ☐ Yes ¾☐ No

**Funeral** Director

10e Stete Director

28a-f show rount be notified the ŏ 'natural', or items 23a death 72 hours after

Funeral

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Be Completed

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Hygiena. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event once. Physician /Medical

Baltimore, Maryland 21215-0020

Examiner and certificete be axec physician a s the burial-Box 68760 Po P.O. Records, Division of Vital

Physician/Medical Examiner

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Completed

Be To

Certification:

al or Attending Physics after death.

In Director: After this ed in by the funeral d within 24 hours at To the Funeral D completaly filled it Hospital Medical

Items: 23a part I 27 28a-f per MEO G-752 10/31/97 dh 1. Decedent's Name (First, Middle, Last) 2. Dete d OCTOBER 09, 1997 William Parker Ramsey 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE COUNTY 36 MILLSTONE ROAD RANDALLSTOWN 5. Social Security Number if Under 1 Year if Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) 1☐M 2□ F Months Days Hours 298-42-9815 Yrs. 37 NOV 24, 1959 Ohio Usual Residence of Decedent 10h County 10c. City. Town or Location MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 36 Millstone Road 21133 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Carpenter Home Improvements 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) James Troupe Ramsey Kyoko Tamura 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Kyoko T. Yoshimura/mother 36 Millstone Rd. Randallstown, MD 21133 of Disposition (Name of Disposit 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 1 Buriel 2 XCremetion 3 Removal from State Metro Crematory, Inc. 10/11/97 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licens Name and Address of Fecility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 George E. MacNabb

299 Frederick Rd. Baltimor

290 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause on each line. Immediete Ceuse (Finet diseese or condition resulting in death) NARCOTIC INTOXICATION AND CIRRHOSIS OF LIVER Due to (or es e consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

				24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
25. Was case referred to medical exeminer?			26. Plece of I	Deeth (Check only one)	
1∰Yes 2□ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpetient 3☐	DOA Other: 4 Nursin	g Home 5 ☑ Residence 6 □Oth	ner (Specify)
27. Manner of Deeth 1 ☐ NatureI 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of injury (Month, Dey Year)	28b. Time of p injury p	28c. Injury et Work? 1 Yes 2 KNo	28d. Describe how injury occur unknown	
3 ☐ Suicide 6 Ø Could not be determined		cify)	ory, office	28f. Location (Street and Number City or Town, Stete) 36 Randallstown, Mary	

MARYS PURS oth, Qay, Year)

29b. Signet re end title of certifier

29a. Certifier

O.C.M.E.

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end manner stated.

29c. License number

29d. Date signed (Month, Dey, Year) OCTOBER 10, 1997

se of deeth (Item 23e) (Type, Print) 30. Neme end eddress d person who completed cau MANON. 1

111 Penn Street, Baltimore, Maryland 21201

State Registrar 32 Registrar's Signature ia Daydson-Randell

Mengine has that the way

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. ate of Maryland / Department of Health a Mental Hygiene ITEM#7&19a PER F.H. ITEM#24a PER PHYNS FLM#G752 10/14/97 J.A. Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** George Perry , Jr. 10 09 1997 7:20 a.m. /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** VA MEDICAL CENTER FORT HOWARD FORT HOWARD, MD BALTIMORE If Under 1 Year If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) NORTH CAROLINA **Funeral** Days Months 10 M 20 F Yrs. 79 **Director** -78 9-28-18 242-24-9005 Usual Residence of Decedent with the Maryland 10a. Slate 10b. County 10c. City, Town or Location 10d. fnslde City Llmits ir than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Xes 2 □ No MD BALTIMORE na 10e. Streel and Number 10f. Zip Code 10g. Citizen of Whal Country? To 4707 IVANHOE AVENUE 21212 UNITED STATES Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. hours after 1 Never Married XX Merried XIX Yes 2 No If Yes, Give NAVY Maryland 21215-0020 1 Yes 20No Specify: þ Specify: BLACK\* 3 ☐ Widowed 4 ☐ Divorced Year or Detes: permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other thermany for other traumer. 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 t h CHEMICAL OPERATOR GLIDDEN PAINT CO 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be GEORGE PERRY SR. ODESSIA WATKINS 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) PERY PERY-wife JOHNNIE MAE 4707 IVANHOE AVE, BALTIMORE, MD 21212 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e, Melhod of Disposition Dete 20c. Location - City or Town, State X Burlei 2 Cremelion 3 Removel from Stete FOREST VA CEM. 10-14-97 OWINGS MILLS GARRISON 21. Signatuse of Funerei Service Licensee 22. Name and Address of Facility ladue WM. C. MARCH FH.-4300 Ware WABASH AVENUE 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervei Between Onset and Deeth **Physician** fmmediete Ceuse (Finel diseese or condition resulting in deeth) /Medical Examiner Prostate Cancer Due to (or es e consequence of): Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last burial-tran Brid Due to (or es e consequence of): physician in the burial Box 68760 Physician/Medical Due to (or as a consequence of): 2 attending 985 ò P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? å signed by 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ George 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? The law page 2 certificate has 1 ☐ Yes 2 ☐ No as Division of Vital director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1☐ Yes 2☐ No Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA # lunaral 27. Menner of Deeth 28b. Time of 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Neturel investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - Al home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigellon, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one) 2 To the To the To the I 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 9600 North Point Road, Fort Howard, Maryland 21052 Wen Wu, MD State Registrar

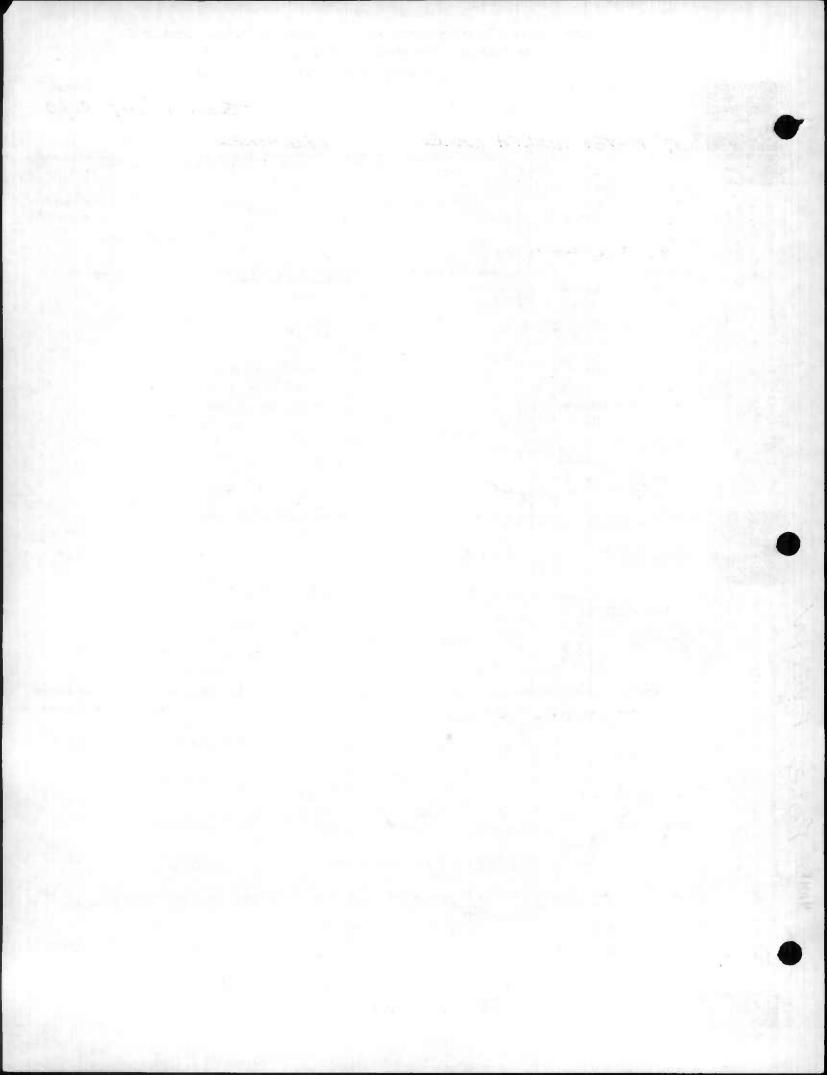
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State of Maryland / Department of Health and Mental Hygiene 7 30892

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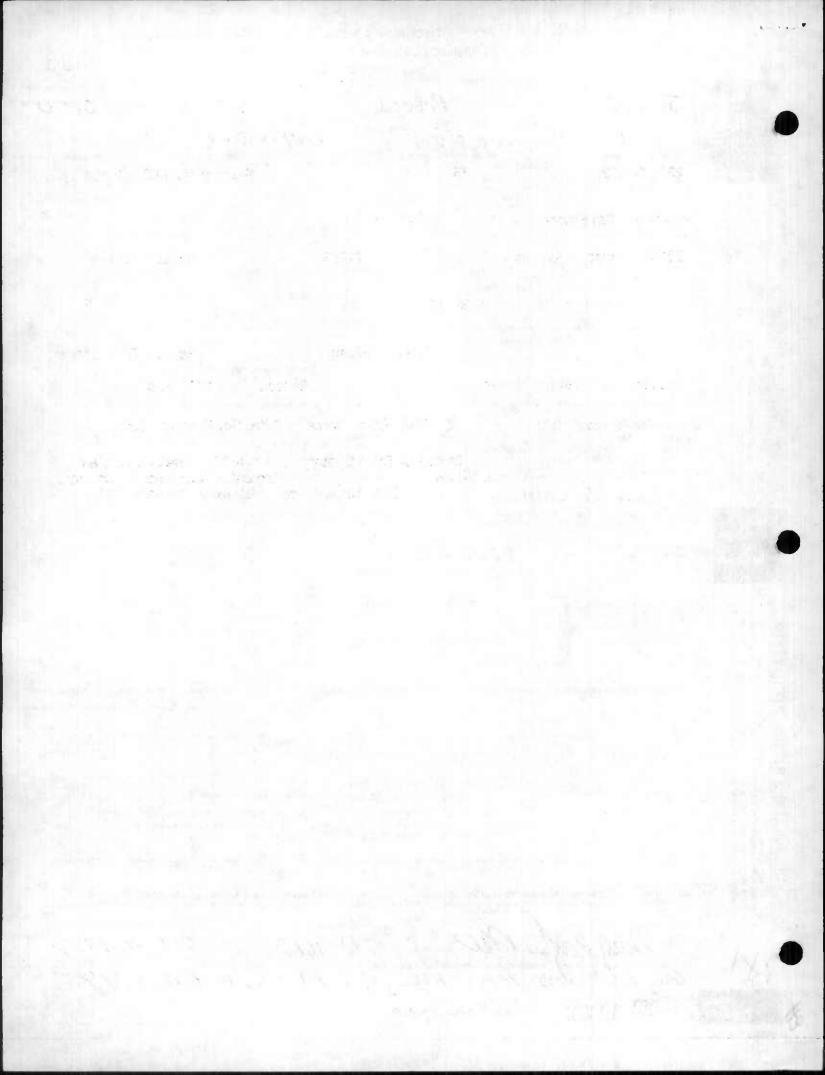
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No.

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Director		236-28-6939 Usual Residence of Decadent		75	110.			February	14, 1922	Kentu	cky
Mo sa		10a. Stata 10b. County		10c. Ci	ty, Town or Loc	ation				10d. in	sida City Lim
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notified	Funeral Director	10e. Street and Number	71 00.	<u> </u>	UI KVII	10f. Zip Code	0		10g. Citizan of	What Country?	-
23a or		3218 Texas /	Avenue			2123	0.4				
itams 2	Jer	11. Marital Status	12. Was Dacedan	t Evar in U	J,S. 13. W		0 4 of Hispanic Origin? ( uban, Mexican, Pua	Specify Yas or No	United 14. Rac	ca - Amarican inc	dian,
or its		1 Navar Marriad 2 Married						irto Rican, atc.)	Bla	ck, Whita, etc.	
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and is ma		19a. informant's Name/Ralationship	(Type, Print)		19b. Mailing	g Addrass (Stra	aet and Number or F	Rural Route Numb	er, City or Town	, Stata, Zip Code	)
of Health item 27 other tr		Mrs. Ada Preece/Wit	fe			Texas Av	venue Par	kville, M	aryland 2	21234	
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Depertmen Important: any injury once.		21. Signatura of Funeral Sarvica Lic	ensee Brian A.	Wille	m 22.	Nama and Add	drass of Facility Le	eonard J. R	ruck Funer	al Home,	Inc.
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kaminer	Examiner	disease or condition resulting in death)	a		or as a consequence as a consequence						mont
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s been signed by the ettendir	Completed b							24a. Was	an autopsy omed?	24b. Were au available completi of death	on of causa
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d d d	<b>U</b> L	29a. Certifier 1 Certifying P	Physician: To the best	r axamına	wiedge, death o tion end/or inva	occurred at tha estigation, in my	tima, data and place y opinion, deeth occ	e, and due to the curred at tha tima,	cause(s) and me date and piece,	enner es stated. and dua to tha c	ause(s)
n 24 hours efti ne Funeral Dis plefely filled In	edicai	(Check only 2 Madical Exa	and mannar st	atau.							
within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medicai	2 Madical Exa	and mannar st	atau.		29c. Lica	nsa number		29d. Data signe	d (Month, Day, )	'ear)
within 24 hours efter death. To the Funeral Director: After completely filled in by the funer		one)	and mannar st	17	P. A.	29c. Lloa	nsa number		2		
within 24 hours eft. To the Funeral Discompletely filled in	2	29b. Signature and little of certifier	and manner st	0	23a) (Tuna D	0	rinsa number 4/16/7 Rd G		Oct	11,15	

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygien 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Olga Pensel OCT 11, 1997 3:55 am /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 228 Ridgeway Road Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
JULY 29, 1914 Massachusetts 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Days Yrs. Director 214-30-6037 83 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits or 28a-f show the Medical Examiner must be notified at MD Baltimore Catonsville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 228 Ridgeway Road 21228 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c. Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural". cr. is any injury or other traumatic events. 1 Never Married 2 Married White þ Specify 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Trofim Kozak Fatimia Marchuk 19e. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Pensel/daughter 228 Ridgeway Rd. Catonsville, MD 21228 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 10/13/97 Baltimore, MD 22 Name and Address of Fecility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Edward A Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in death) Lycars Examiner Examiner siclan end buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Box 68760, physiclan Physician/Medical Due to (or es a consequence of) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by Records, 24e. Wes an autopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death? page 2 s 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physicien: The safer deeth.

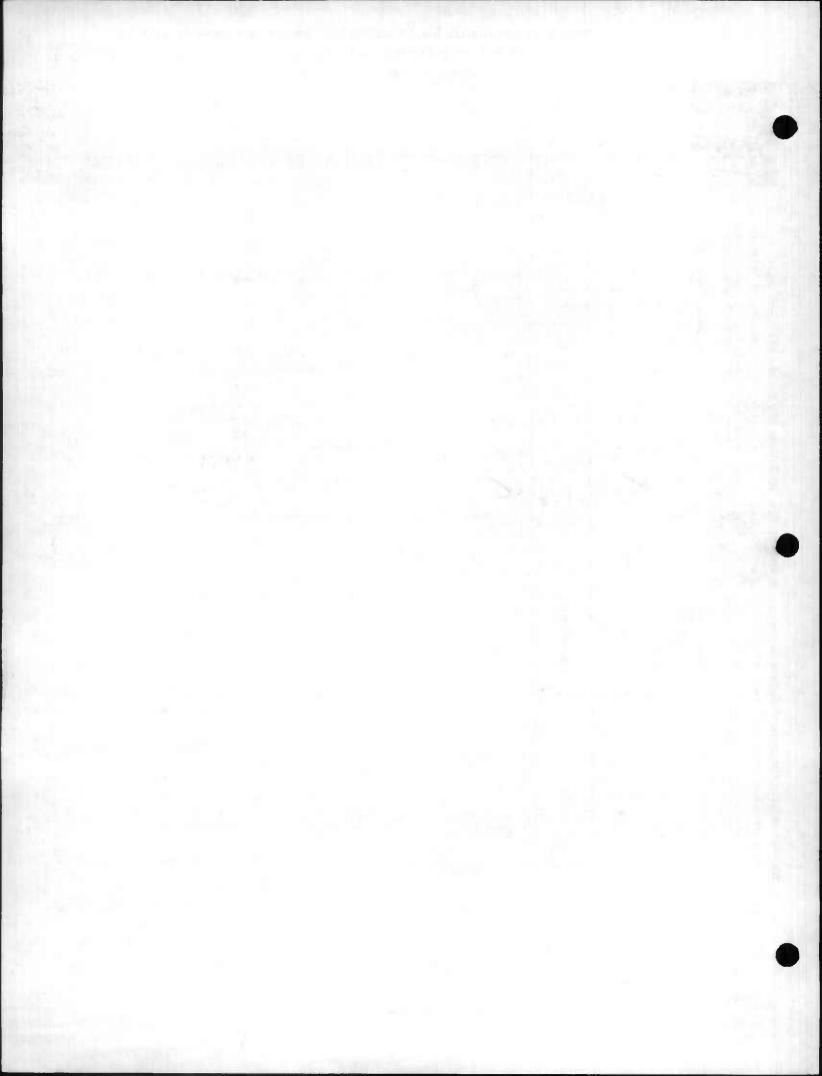
It Director: After this certificate of in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 2 4 Homicide H hours ospital † Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40048 10-13-97 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt. MD 405 Frederick Rd 005 # 31. Date 06 Font 1. 044. 1997

\$2, Registrar's Signeture June Daydson-Handell

**DHMH 16 Ray 6/95** 

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey 1 9 9 7 **Physician** OCTOBER 11:26 am ELIZABETH LEE PLUMMER /Medical 4a. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Un or 1 Year Months Days If Undar 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthpleca (Steta or Foreign Country) **Funeral** Months 1□ M 2 F 219-36-1074 91 02-03-1906 N.C. Director Usuel Rasidance of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23a or 25a-f shor the Medical Examiner must be notified at 1 Yes 2 No Director MD. N/A BALTIMORE ã 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 700 WEST 40TH STREET Funeral 21211 12. Was Decedent Ever in U,S. Armed Forcas?

1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Detas: Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Maritel Stetus 14. Rece - American Indien, Bleck, Whita, atc. 1 Never Married 2 Marriad 1 ☐ Yas 2 No Specify: WHITE à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) Elemantery/Secondery (0-12) Coilege (1-4or 5+) 4YRS. ARTIST ARTIST is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) should be ind Mental VIRGIL JACKSON LEE 2 MARGARET MCDONALD 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health. MARGEURITE HOPKINS (DAUGHTER) BLADON RD.-CAMBRIA PHOENIX, MD. 21131. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, Stete 7 1 ■ Burial 2 □ Cremetion 3 □ Ramoval from Steta 4 □ Donetion 5 □ Other (Specify) mportant: If MAPLEWOOD CEMETERY WILSON, N.C. of Funarai Service Licenses 22. Neme end Addrass of Facility any ir HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 23a Part Prior the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock or heart feiture. List only one cause on each line. Approximete intervel Between Onsat and Death Physician Immediate Sauf e (Final disaesa or condition rasuiting in daath) /Medical SERTICENIA ZWK Examiner Due to (or es a consequence of): Physician/Medical Examiner ZENCED'S DINERTICULUM The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated events attending physician and for use es the burial-trans Box 68760. that initiated events resulting in deeth) Lest Due to (or es a consequance of) P.O. ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributa to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to complation of cause of death? 24e. Wes en autopsy performed? Completed peed has l paga 1 ☐ Yas 2 ☐ No 20 No 1 Tas certificata Hospital or Attanding Physician: Be 25. Was case referred to medical 28. Place of Deeth (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 After this 27. Mennerof Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Panding Investigation 1 DNetural death. 1 Yes 2 🗆 No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, offica building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) aftar 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) end manner as steted.

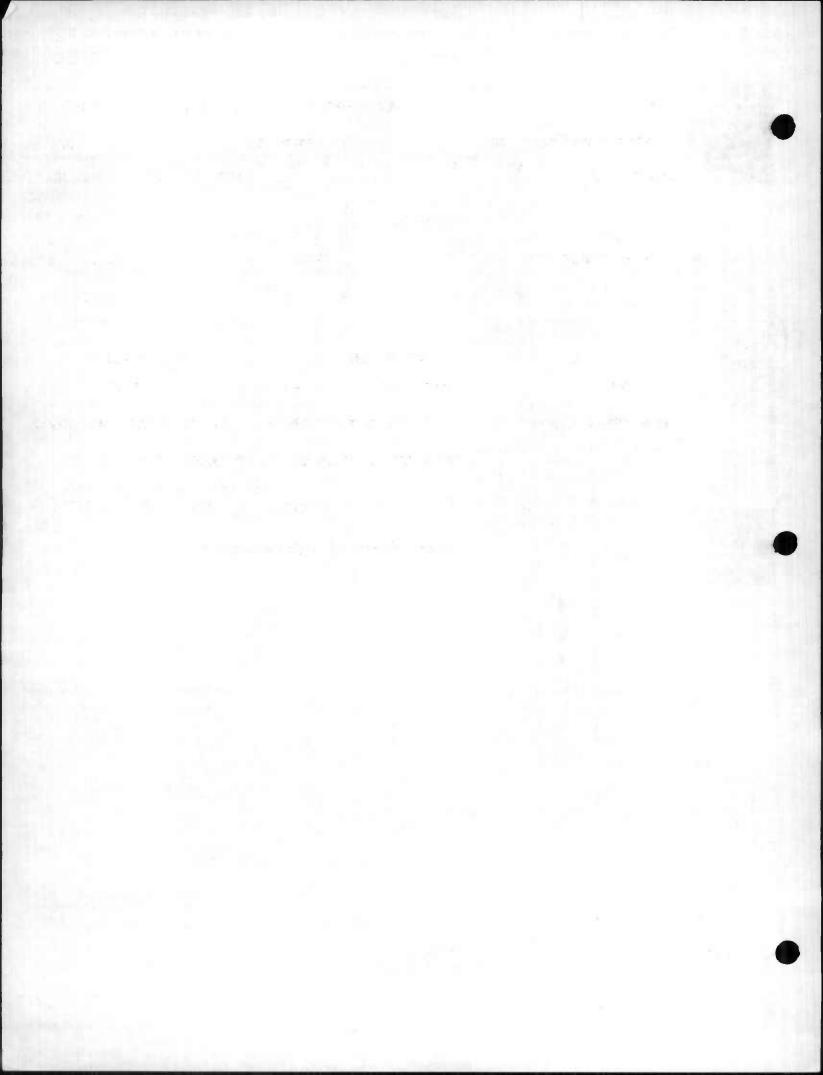
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner steted. edicai 29e. Certifie (Check only one) TOI 29b. Signature and title of certified 29c. Licensa number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 40 LEOU 7801 100X 31. Dete filad (Month, Dey, Year) 32. Registrer's Signeture State

Registrar

Elizabeth Plummer

State of Maryland / Department of Health and Mental Hygiene

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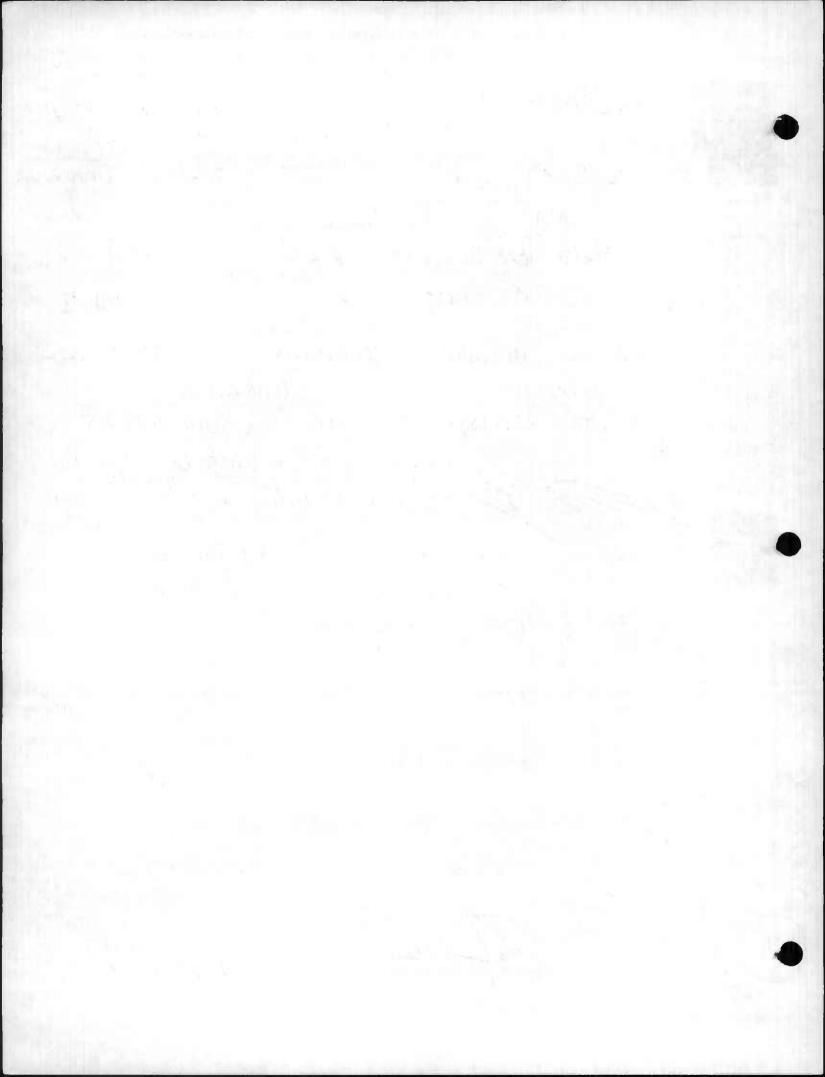
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant'a Nama (First, Middla, Last) 2. Deta of Daath 3. Time of Death Month Physician RICHARD R. Year ROGERS OCT. 13, 1997 4AM /Medical 4a. Facility Name (If not Institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 1021 WITHERSPOON ROAD BALTIMORE CITY 7. Age (In yrs. last birthdey) | If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Months | Devs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□ M 2□ F Yrs. Director 262-05-0834 88 08,1909 FLORIDA Usual Residence of Decedant 10a Stata 10b County 10c. City. Town or Location 10d. Inside City Limits MARYLAND N/A BALTIMORE CITY Ves 2□ No Director rai", or items 23s or 28s-f Examiner must be notifie 200 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1021 WITHERSPOON ROAD 21212-4023 U.S.A Funeral 12. Was Decedent Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: if then "naturel", of à 3 ☐ Widowed 4 ☐ Divorced Specify: NEGRO Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda complated) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) pormit. Pages 1 and 2 should be illed w
Department of Health and Mental Hygien
Important if New 27 is merical other the
any injury or other traumetic. 12TH COKE OVEN OPERATOR BETHLEHEM STEEL CO. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumema) Be JOSEPH ROGERS 2 WINNIEFERD BAINS 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS ROGERS-daughter BALTO, MD. 1021 WITHERSPOON ROAD 21212-4023 20c. Location - City or Town, Steta 20b. Plece of Disposition (Nema of cematery, crametory or other place) OCTOBER 20 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Removel from Stete MARYLAND NATIONAL MEMORIAL PARK 4 ☐ Donetion 5 ☐ Other (Specify) LAUREL, MARYLAND 21. Signature of Funeral Service Lice 22. Name and Addrass of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the diseasa, or complications that caused/tha touth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one causa on each life. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) Cardio Vascular Disease Medical Examiner Due to (or as a consequence of) Sequentielly list conditions, if any, leeding to Immadiete cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events rasulting in death) Last 밁 Due to (or as a consequence of): physician s the buria Box 68760. Physician/Medical Due to (or as a consequence of): attending Pert fl. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 4 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Wes an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital 25. Wes cese referred to medical examiner? å 26. Place of Death (Check only one) Other: 4☐ Nursing Homa 5 Presidence 6 ☐ Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menger of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? Ather Division 1 Netural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) after a 4 Homleide hours Medical 29e, Cartifian 1 Certifying Phyelclan: To the best of my knowledge, daeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and piece, and due to the cause(s) end manner stated. 29b. Signeture end title of certifian 29c. License number 29d. Data aigned (Month, Day, Year) 97 D35082 13 M.D 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 2323 Orleans St, Baltimere, MD 21224 S. RAMESH 31. Date filled (Month, Dey, Year) OCT 141997 320 Hogistrer's Strature State 14 1997 Registrar

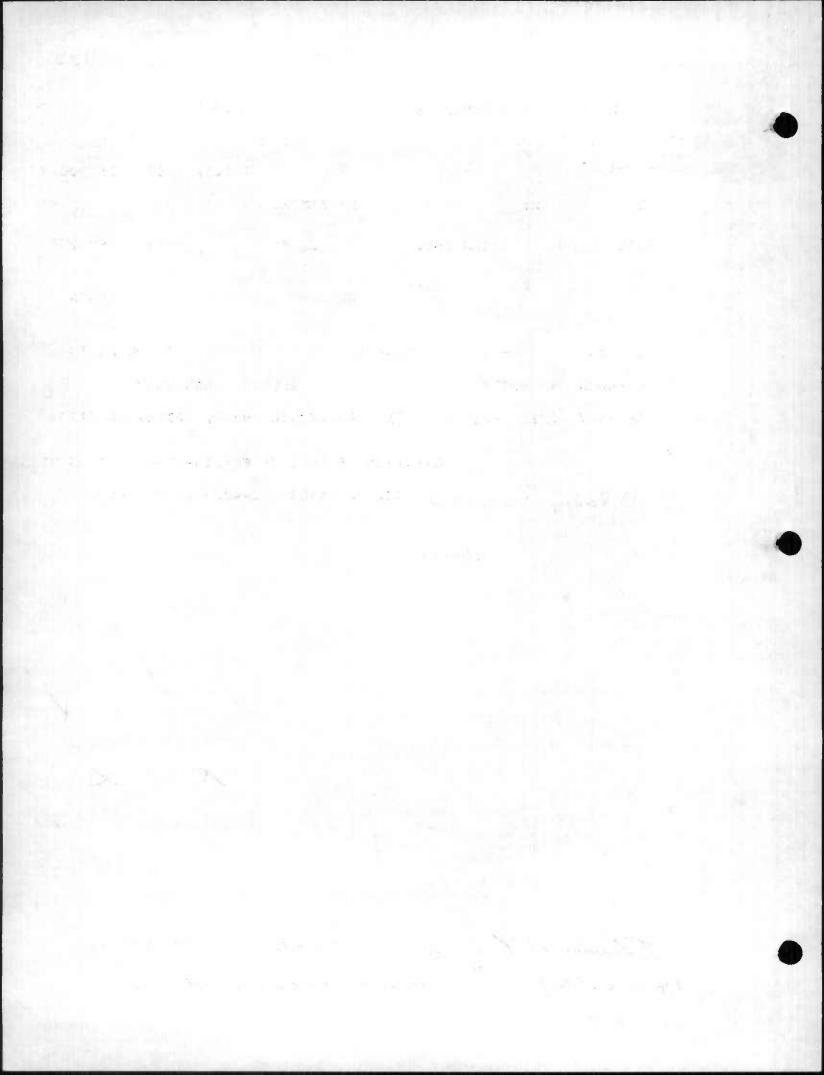


State of Maryland / Department of Health and Mental Hygiene 7

				Ocitino	ate of Death	Reg.	No.	
Physiciar /Medica	n il -	Decedent's Name (First, Middle, Las STEPH E	N Klc	4	4.00.7	2. Date of Death October	9 1497	3. Time of Death
Examine		a. Facility Name (If not institution, give Maryland Ger	reral (H	spital	Baltime	RL C774	4c. County of Dea	VA
Funeral Director	2	35-34-6851  Juan Residence of Decadent	9x 7. Age (in yrs.	last birthdey) If Ur Yrs. Mont	der 1 Yaar II Undar 24 Hr hs Days Hours Mir		9. Bir	thpiaca (State or Forei puntry) UNKNOW
H show		Oa. State 10b. County	A 10c. CI	ty, Town or Location	UNCE			10d. Inside City Limi
23a or 28a-f unt be notifie	5	Oe. Street and Number 4615	Park Heigh	lets Are 101.	Zip Code 21215	10g.	Citizen of What Co	ountry?
or items	by runeral	Marital Status     Never Married 2 Married     Widowad 4 Divorced	12. Was Decedent Ever to U Armed Forces? 1 2 Yes 2 No If Yes, Give Year or Dates:	0 4	cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
lygiene. Tr, tre Modical Ex		15. Decedent's Ed (Specify only highest gre Elementary/Secondary (0-12)	ucation	16a. Decedent's L (Give kind of iife. DO NO	work dona during most of w Tuse retired)	orking 16t	o. Kind of Business	
th and Mental Hygiene. 7 is marked other than traumatic event, train To Re Comm	5	7. Father's Nama (First, Middle, Last)	ununnun	$\mathcal{U}$	18. Mother's Na	ame (First, Middle, Mei		nown
and Mental Hyginis marked other summit event, I	2	unki	now	405 84-18 444	W	Monown		
other traus		19e. informant's Name/Relationship (7	Randolph	300	ess (Street end Number of F METVO Pla	va BAU	MO21	215
- F	2	0a. Method of Disposition	Removal from State	Place of Disposition (cametery, cremetory)	Neme of or other piece)	Dete 200	. Location - City or	Town, State
Department Important: I any injury o	-	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		22 Name	and Address of Facility A	BERT P. U	Jylin Fl	1 PA
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2 should						24a. Was an a performed		Wera autopsy finding aveilable prior to complation of cause of death?
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figar ov. p		6 Was onen referred to medical						
l director, pa	3 2	5. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□	Other:	eath (Check only one) Home 5 Residence	e 8 Other (Spe	cify)
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23e or 28a-f	al Director	10e. Street and Number 3504 VAR	GAS CIRC	LE apt.	3b 10f. Zip Code	21244		10g Citizen of V	What Countr ED S	TATES
or Nema	by Funeral	11. Marital Status  1XXevar Marriad 2 ☐ Marria 3 ☐ Widowad 4 ☐ Divorcad	12. Was Deceda Armed Forca ad 12 Was 2 If Yas, Giva Yaar or Data	s? □No ARMY	3. Was Dacedant of H If Yas, specify Cub 1 ☐ Yas XXNo	dispanic Origin? (S an, Maxican, Puart Spacify:	pecify Yas or No- o Rican, atc.)		ea - Amaricar ck, Whita, at /: BL	
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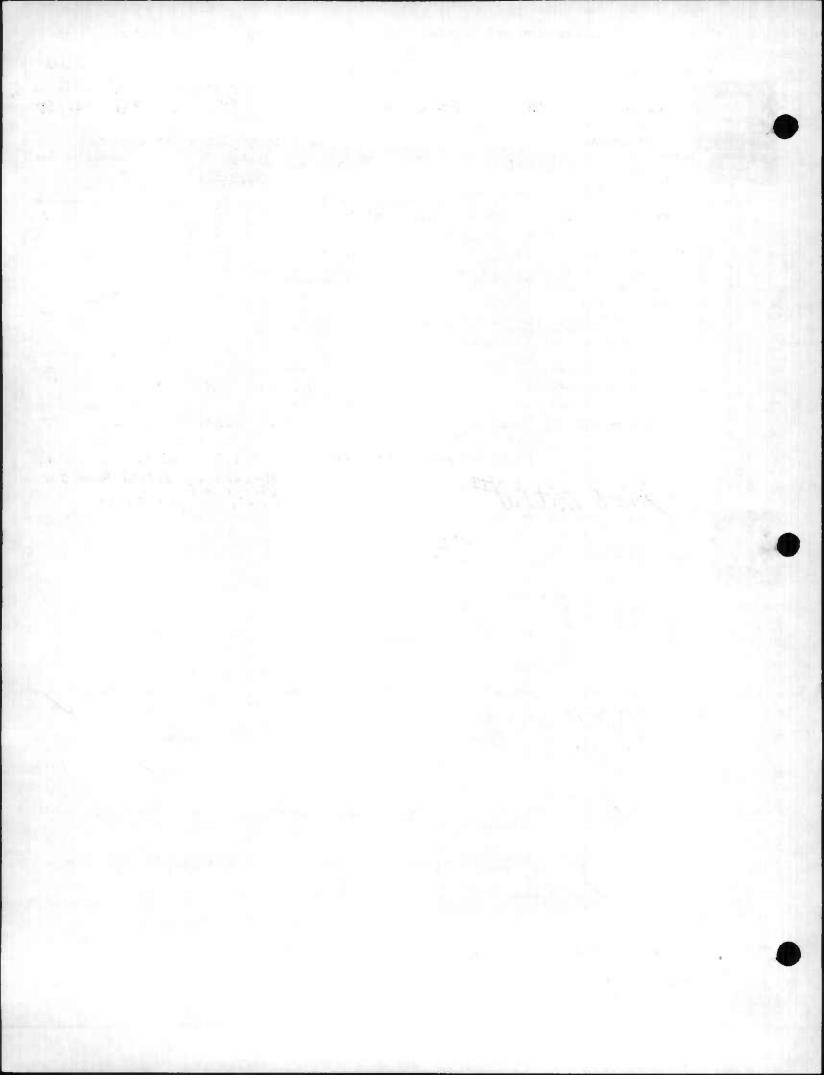


State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 10th 13 Bay 1997 Margaret Knox Rossmann 12:15pm /Medical 4e. Fecility Name (if not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Broadmead Cockeysville Baltimore 5. Sociel Security Number If Under 1 Months H Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) 7. Age (in yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 XF 96 Director **Yrs** 212-46-6885 April 10, 1901 Maryland Usuel Residence of Dacedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Baltimore Cockeysville 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13801 York Rd. 21030 items 23a United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black White etc. 72 hours after 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White À 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within: nent of Health and Mental Hygiene. nt: If item 27 is marked other than "r Elementery/Secondery (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Fethar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be Osma Knox Gardner Lillian Margaret Steenken 19a. Informant's Neme/Reletionship (Type, Print) 19b. Melling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau Janet Rossmann Lundvall/daughter 203 Turnbridge Rd. Baltimore, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 □ Cremetion 3 □ Ramovel from Stete 10/17/97 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. 6500 York Rd.
Boultimore, MD 2/2/2 21. Signeture of Funeral Service Licenses 23 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory erre shock, or heart feliure. List only one cause on each line. Approximete Intervei Between Onset end Deeth **Physician** /Medical Immediete Ceusa (Final disease or condition rasulting in daeth) Examiner Dua to (or as e consequance of) Examiner Sequantially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 2 Due to (or es e consequence of) ğ Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. ä 23b. Did tobacco use contributa to the cause of death? Ē 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown bengis top ed p þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed NIA page 2 1 Yes 2 10 No 1 ☐ Yes 2□ No Be 25. Was cese referred to madical exeminer? 26. Place of Deeth (Check only ona) Hospitel: Othar: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA glig 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred After Attending 1 DNaturel 5 Panding investigation death. 1 Yas 2 No Director: A 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) or A 4 Homicide Hospital of To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Phyelclan: To the best of my knowladga, daath occurred et the time, dete end plece, end due to tha cause(s) and menner es steted. 29a, Certifier 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, daeth occurred et tha tima, data and place, and due to the ceuse(s) end manner steted. 29b. Signeture end title of certified 29c. License number 29d. Dete signed (Month, Dey, Year) ctober 13,1997 30. Name end eddress of parson who completed cause of death (Itam 23e) (Type, Print) York Rd, Cockeysville, MD 21030 32. Registrer's Signetu 31. Date filed (Month, Dey, Year) State

DHMH 16 Rav 6/95

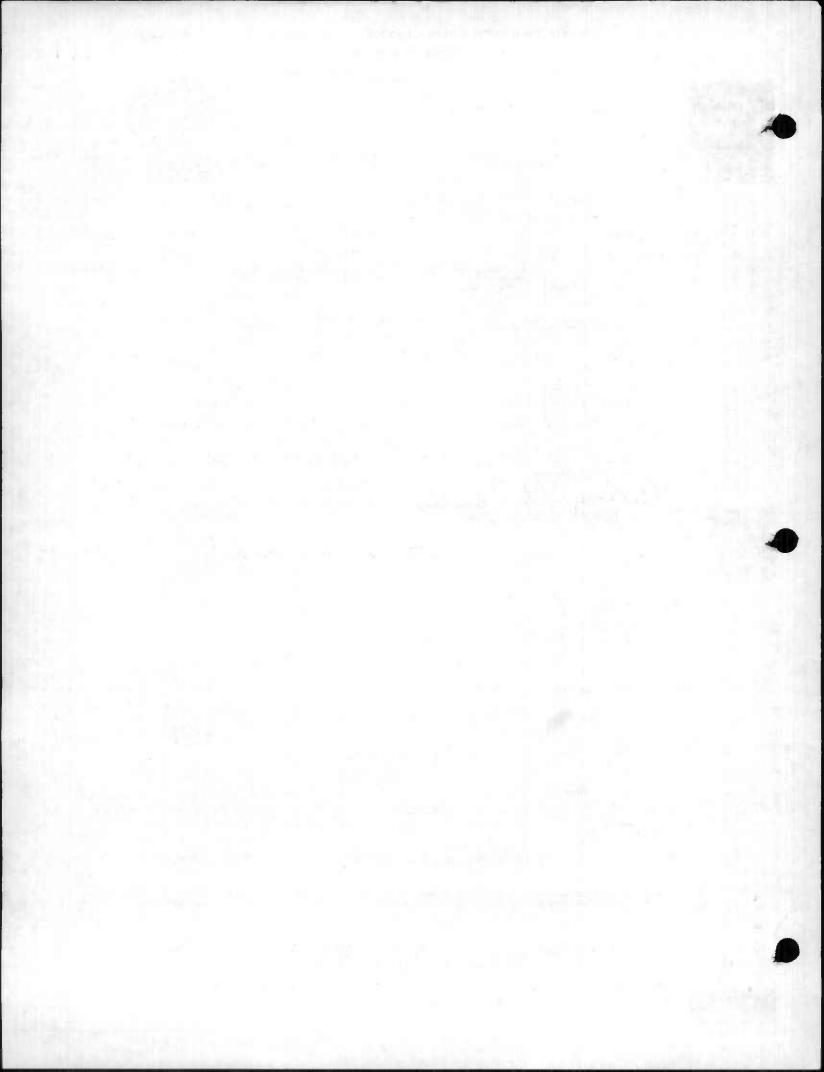
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 3 0 9 0

					00	rtificat	C OI	Dealli			Reg. No.			
Physiciar	_	1. Decedent's Neme (First, Middle	, Last)							2. Date of Dec	eth Day	Year	3. Time	of Deeth
Medica/		John Emil	Rasch	ka Sr	•				(	Octobe		997	6:45	5PM
Examine		4a. Facility Neme (If not institution		imber)				4b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
بيبك		1409 Vesper	Ave						dalk		Balt	imor	е	
uneral		5. Social Security Number	6. Sex 1X M 2□ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Birt (Month, De)	h v, Year)	9. Birthp	place (Stete	e or Foreign
rector		213-07-2476	122 101 201	82	Yrs.					Mar 27		Minr	nesot	a
3		Usuel Residence of Decedent  10e. State 10b. County		10c Cit	y. Town or Lo	ocation						-	Od. Inside	City Limite
e a	5	Md Balti	maxa									1		s 21XNo
If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at	ect ect	10e. Street and Number	more	Du	ndalk	_	0-4-				40- Ohio61	AT -1 0		1
0 5	ă		*			10f. Zip					10g. Citizen of	What Cour	ntry?	,
23	20	1409 Vesper			0 1.0		122				USA			
E J	Funeral Director	11. Maritei Status	Armed Fo		,S. 13.	Was Deced If Yes, spec	ent of H	lispanic Ori an, Mexicar	gln? (Spe n, Puerto I	cify Yes or No- Rican, etc.)	14. Rad Bla	ck, White,	etc.	
o a	by F	1 ☐ Never Merried 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	ve ev		1□Yes	No CK	Specify:			Specif	v: Wh	ite	
	8	15. Decadent	Year or D	Jales.	16a Doso	dent's Usua	1 00000	ation			10h Vind of B			
200	Completed	(Specify only highes	t grede completed)		(Give	kind of wor DO NOT us	rk done	during mos	t of workli	ng	16b. Kind of B	usinessin	uustry	
9	Ĕ	Elementery/Secondary (0-12)	College (	1-4or 5+)							D - 1-1-	0.1	-	
1 6		17. Fether's Name (First, Middle,	Last)		Cran	e Op	era		er's Name	(First, Middle,	Beth . Meiden Sumen		eel	
2	Re	Joseph Rasch	•						Ols			,		
E P	0	19a. Informant's Name/Relations			10b Mailie	na Addraec	(Street				r, City or Town,	State 7ir	Code	
T T S					11.11									
ther		Emma Raschka 20a. Method of Disposition	/ wife	20h. F	Place of Dispo	9 Ve		r AV	e B	Dete	ore, Me			
0.0		Burial 2 Cremetion		State	cemetery, cres	metory or o	ther plea							
any Injury or	-	4 Donation 5 Other (S)		Ch						-15-97	Balt	imor	ce, M	Id
any Ir		21. Signature of Funeral Service I	n n		22	Name and Conn	d Addre	ss of Facili	ı ınera	al Hom	e of D	unda	alk	
		Unthony	Lolt (	mul	ly	7110	Sc	ller	S Po	oint R	d 212			
_	Н	23a. Part1. Enter the disease or shock, or heart failure list	complications that only one cause on o	caused the deat	h o not ent	er the mod	e of dylr	ng, such as	cardiec o	r respiretory er	rest,		Approximation Interval B	ete etween
ician													Onset and	d Death
dical niner		Immediate Ceuse (Final disease or condition		M.	eTATA.	Tie	LVI	4 6	an	2			MUN	14
		resulting in death)	<b>6</b> .		or as a consec		,							
¥ 5	Examiner											į		
for usa as the bunal-trensit	E	Sequentially list conditions, if any, leading to immediate	6.	Due to (o	or as a consec	quence of):								
unial		r any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events										t		
the b	edical	thet initieted events resulting in death) Last	С	Due to (o	r es e conseq	uenca of):						1		
Sa as	Me	, south y ar about, cast										1		
Su Jo			d											
oio l	Physician	Part II. Other significant conditio	na contributing to d	eath but not res	ulting In the u	nderlying ca	ause giv	en in Part I		23b. Did t	obacco uae co	ntribute to	the cause	of death?
dateched	5									10	res 2 No	3 Pro	bably 4[	Unknown
2 3	2													
should	5									24a. Was	an autopsy rmed?	ev	ere autopsy eiiable prio	r to
O C	ble									E.S.	/	of	mpletion of death?	cause
paga	0									101	es 2□No	1[	Yes 2	□No
rector, pa		25. Was case referred to medical						26. Piece	of Deeth	(Check only o	ne)			
	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpetier	nt 3 DO	A Oth	Ar.		ne 5 Resid		ner (Specil	(v)	
		27. Manner of Death	28e. Date	of Injury	28b. Time of		8c. Injur Wor				now Injury occur		,,	
e funer	2	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investig		th, Dey Year)	Injury	М		Yes 2	No					
in by the		3 ☐ Sulcide 6 ☐ Could n	ned 200. Place	of Injury - At he	ome, farm, str	eet, fectory	, offica		2		Street end Numi	ber or Rura	al Route Nu	mber,
ed in by the funeral	La.	4 Homicide	build	ing, etc. (Specif	y)					City or Tow	m, Stete)			
		29a. Certifier 1□ Certifying	Physician: To the	best of my kno	wiedge, death	occurred o	et the tir	ne, dete en	d piece, e	end due to the	euse(s) end m	enner es s	teted.	
plataly fill	200	(Check only 2 Medical I	xaminer: On the b	asis of examina ner stated.	tion and/or In	vestigation,	in my o	plnion, dea	th occurre	ed at the time,	date and place,	end due to	the cause	(s)
E .	2	29b. Signature and title of certifier				290	. Licens	e number			29d. Date signe	d (Month,	Dey, Year)	
8		. // //					N. 11	-111			10/13/9	7		
8		Ch hill	100				113/ 60	// ~						
compla		30. Name end eddress of person of	ZDL	on of death /it	0 22a) /T.m.	Print)	917	119			. 7/3//	7		



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

3. Tima of Death

10:35AM

10d. Insida City Limits 1 Yes 2□No

Approximata Intarval Batween Onset and Death

WHITE

Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Date of Daath **Physician** 1997 OCTOBER 8, WILLIAM B. RAFFERTY /Medical 4e. Fecility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** #9 MIDVALE ROAD BALTIMORE if Under 1 Yaer 5. Social Sacurity Number If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplaca (State of Country) 05-15-1912 MARYLAND 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funerai** Days Hours 1 M 2 □ F 215-07-0739 85 Yrs **Director** Usual Rasidance of Decadant 10a. Stale 10b. County 10c. City, Town or Location Director 25a-f natifie MD N/A BALTIMORE 8 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 8 munt be 9 MIDVALE RD Herms 23a 21210 USA Funeral 12. Wes Decedant Evar in U.S. Armed Forcas? 13. Was Decadent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Stalus 14. Race - Amarican Indien, Bleck, Whita, atc. 1 ☐ Yas 2 No If Yes, Give Yaar or Datas: 1 Navar Married 2 Married b Maryland 21215-0020 Specify: þ 3 Widowad 4 ☐ Divorced Completed the Medical 16a. Decadant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratirad) 15. Dacadant's Education (Spacify only highest grada completed) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elamantary/Secondary (0-12) 5+ LAWYER LAW 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) 2 should be figure 1 marked JOHN PATRICK RAFFERTY DOROTHY HARTIE 19a. Informant's Nama/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) ages 1 and 2 sh rit of Health and tilf flam 27 is m y or other traum SUSAN MAGRI (DAUGHTER) 2405 TANEY RD. BALTO., MD. 21209. Baltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - Cily or Town, Stata 1 Burial 2 Cremetion 3 Ramoval from Stata mportant 4 Donetion 5 Othar (Specify) OAKLAWN CEMETERY 10/13/97 BALTO., MD. 21. Signature of Funaral Service Licensea 22. Nama and Addrass of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. 23a. Part1. Enter the disease, or complications that caused the death. Do not an ar the mode of dying, such as cardiac or respirelory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final disaesa or condition rasulting in death) Contact gunshot wound of head Examiner Dua to (or as a consaquanca of): Examiner be executed -tran Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Diseasa or injury that initiated avants rasulting in death) Last and Dua to (or as a consequence of): 68760 Dua to (or es a consaquenca of):

Physician/Medical by Completed Be

tha director, Medical Certification: To

physician attending | Box ( P.O. à signed t Records, peed paga 2 s certificata Division of Vital nding Physician: this After

> 10 State

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 25. Was casa rafarred to madical axaminar? XXYas 2□ No 27. Mannar of Death 1 Natural 2 Accidant 3. Sulcida 4 ☐ Homicida

29a, Cartifiar

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 Panding Invastigation 6 Could not be datarmined

28a. Data of Injury (Month, Day Year) 28b. Tima of Injury Found 10-2-97 unknown 28a. Place of Injury - At homa, farm, streal, factory, offica building, atc. (Specify)

Othar: 4 Nursing Homa SXRasidanca 6 Othar (Specify) 28c. Injury at Work? 1 Yas 2 No

Self inflicted gunshot wound 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) # 9 Midvale Road

24a. Was an autopsy

Inspection

28d. Dascribe how injury occurred

26. Placa of Daath (Check only ona)

1 Yas 2 No

It one

Baltimore City, Maryland

Cartifying Physician: To the basi of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura end titla of cartifiar 30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print)

29c. Licansa number O.C.M.E.

29d. Dale signed (Month, Day, Year) OCTOBER 10, 1997

23b. Did tobacco usa contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

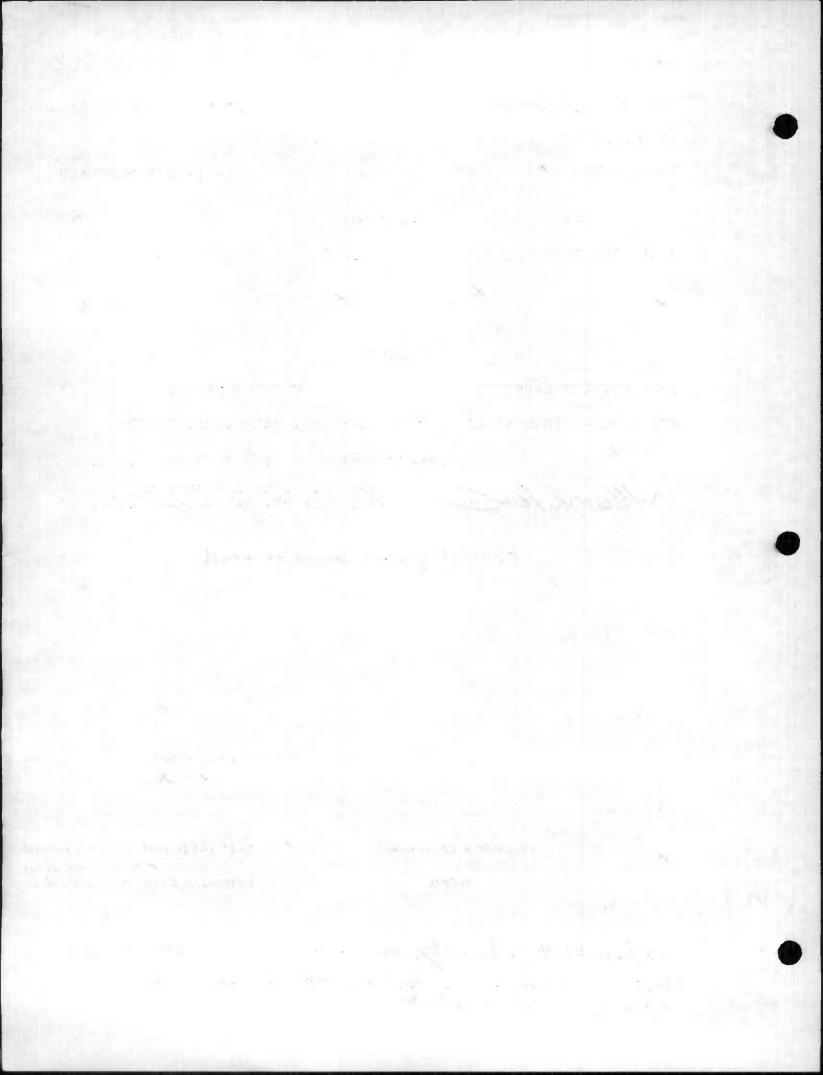
24b. Wara autopsy findings availabla prior to complation of causa of daath?

1 Yas 2 No

Radentz 111 Penn Street, Baltimore, Maryland 21201 Stephen 5. 31. Data filed (Month, Day, Yaar)

**DHMH 16 Rev 6/95** 

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month PEGGY SMITH 10:30 BC+ 4e. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth ST AGNES HOSPITAL BALTIMORE CITY If Under 1 Year | if Under 24 Hrs. | Months | Days | Hours | Min. 8. Deta of Birth (Month, Dey, Year) JUL 9 1932 9. Birthplece (State or Foreign Country) MARYLAND 5. Social Sacurity Number 7. Age (In yrs. last birthday) 1□M 20 F 218-34-2240 65 Usual Residence of Deceden 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No MARYLAND BALTIMORE CITY n/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2619 E. FAIRMOUNT AVENUE 21224 U.S.A. 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yes XX No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Maritel Stetus 1 Navar Married 2 Married 1 ☐ Yes 2 💢 🐪o Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Yaar or Detes 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry Elementery/Secondary (0-12) College (1-4or 5+) EDGEWOOD NURSING HOME NURSING ASSISTANT 9th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) EVAN BACON BLANCHE BROOKS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Margaret Anderson/Daughter 5348 Lantern Court, Baltimore, Maryland 21229 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1) Burial 2 Cremetion 3 Ramoval from State 4 Donetion 5 Other Specify WESTERN STAR CEMETERY BALTIMORE, MARYLAND 10 - 1722. Nama and Address of Fecility WILLIAM C. BROWN COMMUNITY F/H 21. Signeture of Funeret Service Licenses 1206 W. NORTH AVENUE 23e. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiretory errast, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting to deeth) ANOXIC ENCEPHACOPATHY Due to (or es a consequenca of): ARREST CARDIAC Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CARDIOMYOPATHY 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en eutopsy 1 ☐ Yes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigetion 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident

physician a 쿭 or A

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23s or 28s-f show edical Examiner must be notified at

al Hygiene.

and 2 should be. Ith and Mental h.

Baltimore,

permit. Pages 1 and 2 at Department of Health and Important. If then 27 is in any injury or other traun page.

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed

Be

2

Certification:

Directo

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Completed

To the Hospital within 24 hours a To the Funeral C

edical State Registrar

Konkonla, MD

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

29c. Licansa number D46704

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basts of examination end/or investigetion, in my opinion, deeth occurred at the time, date and plece, and due to the cause(e) end menner steted. 29d. Data signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

MUTOMBO KAPKONDE STARWES HOSPITAL KANKONRE MUTOMRO 31

6 Could not be determined

color of

31. Dete filed (Month, Day, Year) 14 1997 OCT

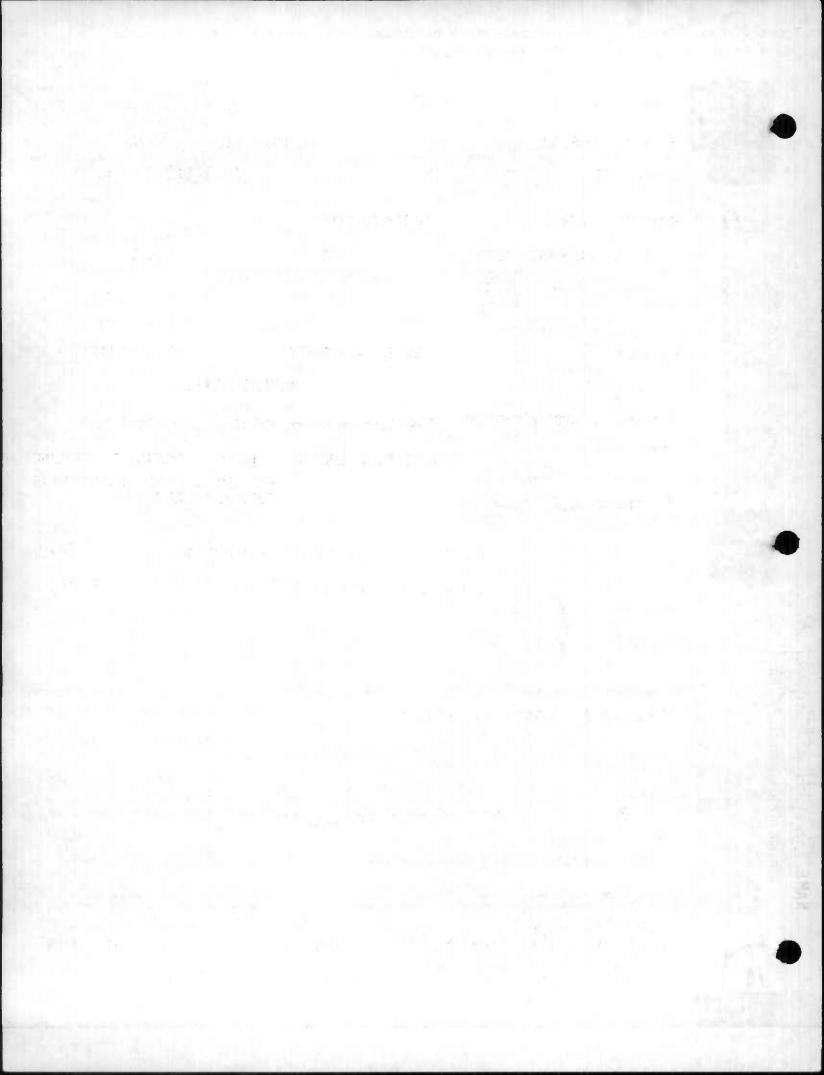
3 Suicide

29a. Certifier (Check only one)

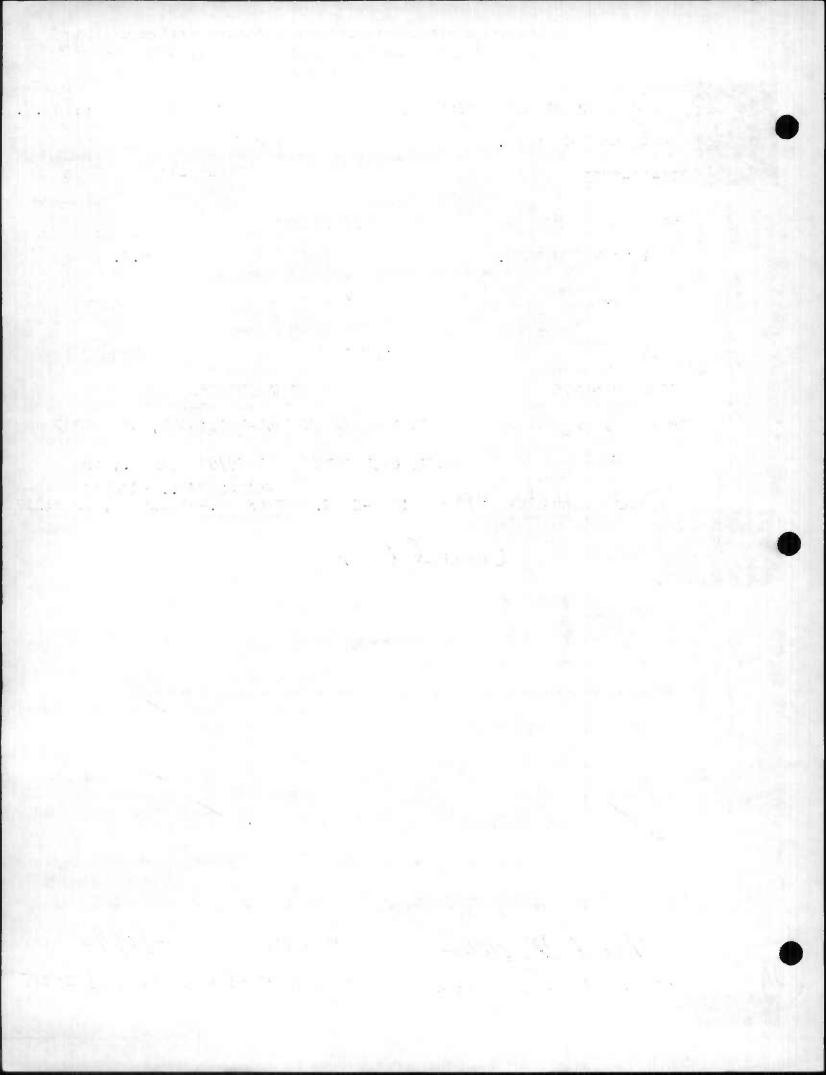
4 Homicide

29b. Signature end title of cartifier





siciar		Decedent's Name (First, Middle	e, Last)		00	· imoa	.0 01	Death	2. Dete of De	Reg. No. eth		3. Time of Death
	1	JOANN COLL		CK STAI	TINGS	3			Month 10	Dey 6	Yeer 97	6:15p.m.
ledica amine:		le. Fecility Name (If not institution			JILING			4b. City, Town, or				0:13p.m.
		2401 GARRISO						BALTIMO	RE		I/A	
eral		5. Sociel Security Number	6. Sex	7. Age (In yrs	lest birthdey,	If Unde	T 1 Year Days	If Under 24 Hrs			9. Birthpl	lece (Stete or Foreign
tor		216-44-2025	10 M 20 F	50	Yrs.	Monena	Days	Hours Min.	8. Date of Bird (Month, De 12-2	8-46	Coun	MD MD
	-	Usuei Residence of Decedent  10e. Stete 10b. County		10c C	ity, Town or L	ocation						ad to the City City
1	_			100.0	ity, rown or E						1	0d. Inside City Limits 1,□,Yes 2 No
Director	3	MD 10e. Street end Number	N/A			-	BALT p Code	IMORE		10g. Citizen of	Milest Cours	XX
		2401 GARRISO	ON BLVD.			101. 2	212	16			J.S.	uyr
Finaral		11. Meritel Stetus	12. Was De	cedent Ever in U	J,S. 13.	Wes Dece		lispanic Orlgin? (S an, Mexican, Puer	pecify Yes or No		ca - America	an Indien,
hv Fire		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	H Voe C	2 □ No Sive		If Yes, spo		an, Mexican, Puerl Specify:	io Rican, etc.)	Specif	ock, White, of BLA	
		15. Deceden	t's Education		16e. Dece	dent's Us	uel Occup	petion		16b. Kind of B		
Completed	1	(Specify only highe Elementery/Secondery (0-12)	st grade completed	(1-4or 5+)	(Give	DO NOT	ork done use retired	during most of wo during most of wo	rking			4
1	5	12	4	(1.40.01)		CLE	RICA	L		GOVE	RNME	NT
Be		17. Fether's Neme (First, Middle,	Last)					18. Mother's Na	me (First, Middle,	Meiden Sumer	me)	
F	2	WILLIAM BLAC	CK					EMMA	COLLIE	R		
		19e. Informent's Neme/Reletions				-		end Number or Ri				Code)
		EMMA ROBERTS	MOTHER	004	7123	BR(	OMPT	ON ROAL				21207
	1	20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion			Pleca of Disponentery, cre	metory or	other plea	се)	Date	20c. Location	- City or To	wn, Stete
	-	4 Donetion To Other (S		ME		CREMA			0/9/97	BALT	0.,	MD
		21. Signeture of Funerel Service	Licansee	0	2	2. Name e	nd Addre	ess of Facility EI	IZABET	H L. P	HILL	IPS
SUC®.	-	23e. Pert1. Enter the diseese, or shock, or heert feilure. List	Hector	CFS	17	721-	27 N	. MONRO	E ST	BALTIM		
edicai Examiner		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events	b	Due to (	or es e conse	quence of	:					
Physician/Medical		resulting in deeth) Lest	d	Due to (	or es e consec	quence of)	:					
SCI		ert ii. Other significant condition	ons contributing to	deeth but not re:	sulting in the u	ınderlying	cause giv	ven in Pert I.	23b. Did	tobacco use co	ontribute to	the cause of death?
by Phy									10	Yes 2 No	3 Prob	eably 4 Unknown
Completed										en eutopsy med?	cor	ore autopsy findings silable prior to repletion of cause death?
E O									10	res 2 No	10	Yes 2 No
		25. Wes case referred to medical exeminer?						26. Piece of De	eth (Check only o	nne)		
m		1 ☐ Yes 2 ☑ No	Hospitei: 1	Inpatient 2	ER/Outpetie			4 LI Nursing F	lome 5 Hesid	dence 8 🗆 Oth	her (Specify	)
To Be	1	7. Menner of Deeth 1 ☑ Maturel 5 ☐ Pendin	g (Mo	of Injury oth, Dey Year)	28b. Time of Injury		28c. Injur Wor		28d. Describe	how injury occur	rred	
2		2 Accident investig	gation			М		Yes 2□No				
2			280 Plan	a of Injury - At h ding, etc. (Speci	iome, farm, st fy)	reet, fecto	ry, office		28f. Location (S City or Tox		ber or Rura	l Route Number,
2		3 Sulcide 6 Could determ	buik									
lon: To		3 Sulcide 4 Homicide  29a. Certifier (Check only 2 Medical	g Physician: To the	e best of my kno	owledge, deat etion end/or in	h occurred	et the tin	me, dete end plece	a, and due to the erred et the time.	cause(s) end m	anner as st	eted. the cause(s)
edical Certification: To		3 Sulcide 4 Homicide  29a. Certifier (Check only one)  6 Could determ  29a Certifyin 2 Medical	g Physician: To th Examinar: On the end me	e best of my kno	owledge, deat etion end/or in	vestigetion	n, In my o	plnion, deeth occu	erred et the time,	dete end plece,	end due to	the cause(s)
Certification: To		3 Sulcide 4 Homicide  29a. Certifier (Check only 2 Medical	g Physician: To th Examinar: On the end me	e best of my kno	owledge, deat etion end/or in	vestigetion	n, In my o	ppinion, deeth occu	erred et the time,	cause(s) end m dete end plece, 29d. Dete signe	end due to	the cause(s)
edical Certification: To		3   Sulcide 4   Homicide   6   Could determ  29a. Certifier (Check only one)   12   Medical  29b. Signeture and title of certifier	g Physician: To the Examinar: On the end me	e best of my kno basis of examine nner steted.	etion end/or in	vestigetion 29	n, In my o	plnion, deeth occu	erred et the time,	dete end plece,	end due to	the cause(s)
edical Certification: 1		3   Sulcide 4   Homicide   6   Could determ  29a. Certifier (Check only one)   12   Medical  29b. Signeture and title of certifier	g Physician: To th Examinar: On the end me	e best of my kno basis of examine nner steted.	etion end/or in	vestigetion 29	n, In my o	polition, deeth occurse number 38972	erred et the time,	dete end plece, 29d. Dete signe	end due to	the cause(s)



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

sician	1.0	ecedent's Name (First, Middle, Las	t) •••	Smit	11	2. Date of Dea	Day Q	3. Tima of Death
edical miner	1/2	Facility Name (If not institution, give	street end number)	BuenoRly	4b. City, Town, or	Location of Death	4c. County	
ral	2	ocial Security Number  6. Security Number  17-03-7197  all Residence of Decedent	CO-A	Yrs. Iest birthdey) If Und Month	ler 1 Yeer If Under 24 Hrs s Days Hours Min		(, Year)	9. Birthpled (State or Foreign Country)
tor	10a	State 10b. County  Md  B	alto 10c.	Catonsu	110			10d. inside City Limit
al Director		Street and Number		10f. 2	21228		10g. Citizen of V	What Country?
by Funeral	11.	Marital Status  1 Never Married 2 Married 3 Nidowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1 Series 2 No If Yes, Give Year or Dates:	7/3	pedent of Hispanic Origin? (Specify Cuben, Mexican, Puer 2) No Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - American Indian, ck, White, etc.
Completed		15. Decedent's Ed (Specify only highest grad lementary/Secondary (0-12)	ucation de com <i>pleted)</i> College (1-4or 5+)		sual Occupation work done during most of wo use retired)	rking	16b. Kind of B	usiness/industry
To Be Co	17	Father's Name (First, Middle, Last)  Orris Smith	<i>N#</i>	77430		me (First, Middle,	Melden Surnam	ne)
	190	Linformant's Name/Relationship (7)	- Brother-In-L 20t Removal from State	0	ess (Street and Number or R Dedurdule Teme of r other piece)	Road	Ba 14/1 20c. Location -	none, Mul City or Town, Stata
	21.	Signature of Funerel Service Licens		Crest law 22. Name Mari	and Address of Facility,  F. H. Was  4300 Wal	10-16-97 +	Dalt,	Balto red
Examiner	resi	nediate Cause (Final base or condition ulting in death)  quentially list conditions, ny, leading to immediate se. Enter Underlying use (Disease or injury	Due to	o (or as a consequence o		TPALA	F.C.	Onset and Deeth
an/Medical	mat	ulting in death) Lest	Due to	(or as a consequence of	'):	-		
Completed by Physician/M	Part	II. Other significant conditions co	A				obacco use co	ntribute to the cause of death
npleted t	_	Peripheral	Hortic 1 Vascular	Diseas	6	24a. Was a	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
Be		Was cese referred to medical examiner?	Hospital:		0	eth (Check only o		1 □ Yes 2 No
Certification: To	27.	Manner of Death  Manual of Death  Manual of Death  Mature  Mat	28a. Date of injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?  1 Yes 2 No	lome 5 ☐ Resid 28d. Describe h	ow injury occur	red
al Certifi		4 Homicide determined	building, etc. (Spe		ory, office	City or Tow	n, Stete)	per or Rural Route Number,
Medical	29b.	(Check only one) 2 Madical Exami	ner: On the basis of exami and manner stated.	nation and/or investigation	on, in my opinion, death occi 9c. License number	irred at the time, o	late and place,	and due to the cause(s)  d (Month, Dey, Year)
1	30.1	Name and address of person who co	pur r	Mary 22a) (Tuno Brint) (	D32548	(	3ctob	er 9, 199= CENTER
	377	ERRY L COIVI	M M D GERMAN	10 N G		VT	IFDICAL	- CENTER

distribute in Seedah destart Signer P. B. S. Land Lot Bendled . Button gerant of the 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death OSt 1997 Month **Physician** 01.40AM STUDY ESTER OCTOBER /Medical 4a. Fecility Neme (If not institution, giva street end number) 4c. County of Deeth 4b. City Town, or Location of Deeth Examiner Randallstown
If Undar 24 Hrs. 8. Detection of the Min. 8. Detection of the Min. Northwest Hospital Center Baltimore 6. Sex 1 M 2 □ F if Undar 1 Yaar 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (Steta or Foreign Country) **Funeral** Deys Yrs. Director 213-12-8972 Usuel Residence of Decedent April 6, 1920 Maryland the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, ine Medical Examiner mant to notified at 1 TYes 2 NO Directo Baltimore Marriottsville Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4209 Wards Chapel Rd. 21104 death USA 12. Was Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puarto Ricen, atc.) 14. Race - Amarican Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or them any injury or other traumatic event, the Mandal. 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ☒ No Specify: Specify: by 3 ☐ Widowad 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Armco College (1-4or 5+) 10 years Crane Operator Steel Manufacturing 17. Fethar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Ralph Wilson Study Emma Jane Messenger 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21104 (Wife) 4209 Wards Chapel Rd. Marriottsville, MD Adele B. Study 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 10-10-97 Randallstown, MD Wards Chapel Cemetery 21. Signatura of Funaral Service Licensee 22. Name end Address of Fecility Loring Byers Funeral Directors, Inc. 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Randallstown, MD 21133 Approximete Intervel Betwaen Onsat and Death **Physician** /Medical Immediate Cause (Finel SYACI P disease or condition resulting in death) NEUMONIA Examiner Due to (or es e consequence of) Examiner physician and s the burial-transit Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in deeth) Lest Due to (or es e consequence of) certificata be execu Physician/Medical Dua to (or as a consequence of) 98 attending p signed by the a Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ♥ Unknown Division of Vital Records, þ 24b. Were eutopsy findings evailebla prior to 24a. Wes en eutopsy performed? Completed peen completion of ceuse of deeth? has certificata 1 ☐ Yes 2 ☐ No director, 25. Wes cese referred to medical exeminer?
1 ☐ Yes 2 No Be 28. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetiant 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 this 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural
2 Accidant 5 Pending investigation deeth. 1 Yes 2 No e Hospital or Attendi n 24 hours aftar deeth e Funeral Director: A 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. edical To the Hosp within 24 hou To the Fune complately fi 29d. Data signed (Month, Day, Yaar) 29b. Signeture and title of certifier 29c. License number mella, m.o D41410 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 21133. LOGINDER P MEHTA, M.D HORTH WEST HISPITAL CENTER RANDAUSTOWN MO 31. Dete filed (Month, Day, Year)

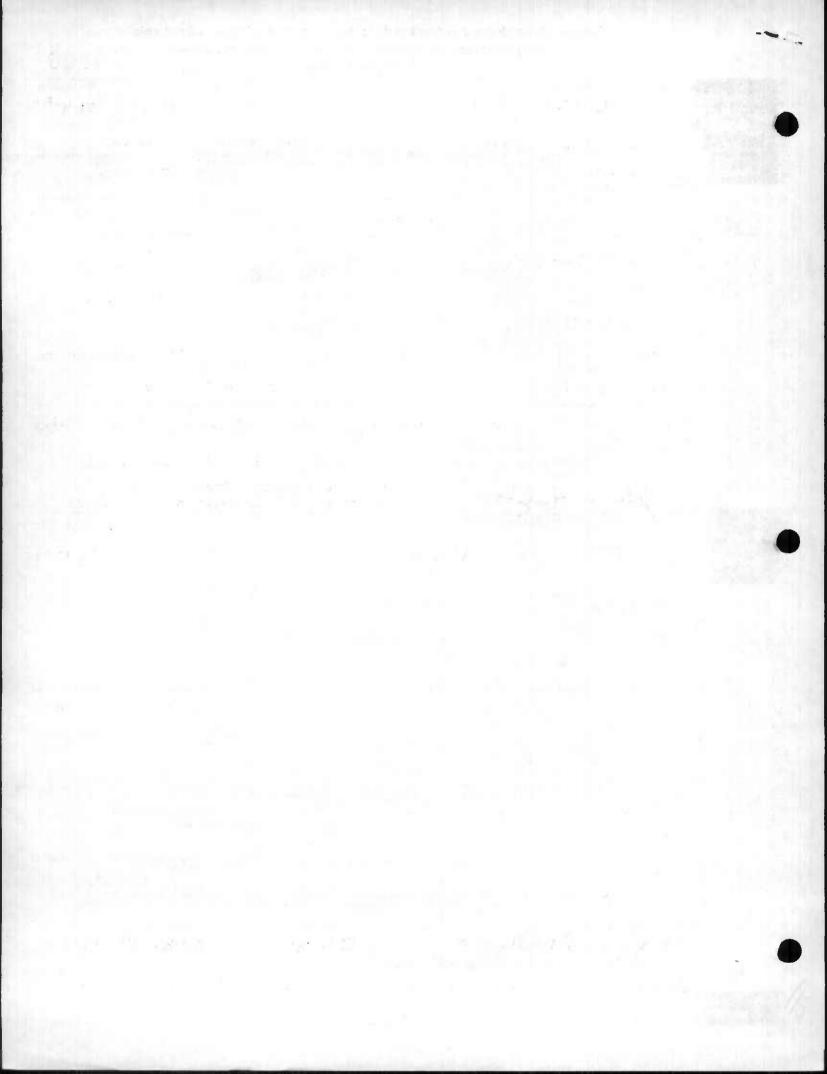
OCT 1 4

32. Registrar's Signature

Julia Savidson Bandsee

Registrar **DHMH 16 Rev 6/95** 

State



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	an	Decedant's Nan	na (First, Middl	e, Last)					2. Data of Deat Month	h Day	Year	3. Time of Death
/Medle				ances E		er			October		997	6:00am
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uneral irector		5. Social Security I  236-24- Usual Rasidance of	3761	6. Sax 1  M 2  ▼	7. Aga (in yr	rs. last birthday) Yrs.	Months Deys	Hours Min.	8. Data of Birth (Month, Day, Mar 13,	<sup>Year)</sup> 1925	9. Birthpl Count West	laca (Stata or Fore try) Virgini
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a or 28a-f show be notified at	tor	Maryland	N/A			Baltimo	re					1 X Yes 2 □
N 28	l'ec	10e. Street and Nu	umber				10f. Zlp Code		10	0g. Citizan of N	Whet Coun	try?
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30908 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death OCTOBER 8, 1997 2:30 PM Mary Naomi Stires 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Charlestown Care Center Catonsville Baltimore 8. Dete of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 1□M QUF Days 215-03-1464 81 Maryland Usual Residence of Deceden 10c. City, Town or Location 10e. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 713 Maiden Choice Ln., #1307 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indien, 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Jacob Singhass Mary Grant 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) C. Chapin Stires/husband 713 Maiden Choice Ln., #1307 Catonsville, MD21228 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 XBurial 2 ☐ Cremetion 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) Druid Ridge Cemetery 10/13/97 Pikesville, MD 21. Signature of Funeral Service Lightness 22. Name and Address of Fecility MacNabb Funeral Home, P.A. de 301 Frederick Rd. Baltimore, MD Edward A. Baltimore 23a. Perfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Dehydratic Due to (or es e consequence of) Proumonio Due to (or es a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 2 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2010

**Physician** /Medical Examiner

physician and s the burial-trans

Name: MARY NAOM! STIR!

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

**Physician** 

/Medical

Examiner

Funeral Director

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Completed

Be

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be nothed at

Baltimore, Maryland 21215-0020

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Wes case referred to medical examiner? 20 No 1 Yes

27. Manner of Death 1 Natural 5 Pending investigation 2 ☐ Accident

6 Could not be determined 3 Sulcide 4 Homicide

Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year)

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

Other: Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28. Place of Deeth (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner as stated.
2 Medical Examinar: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year)

29b. Signeture end title of certifier

ess of person who completed cause of deeth (Item 23a) (Type, Print) M Carpenter MD Maiden Choice Lin Baltimore

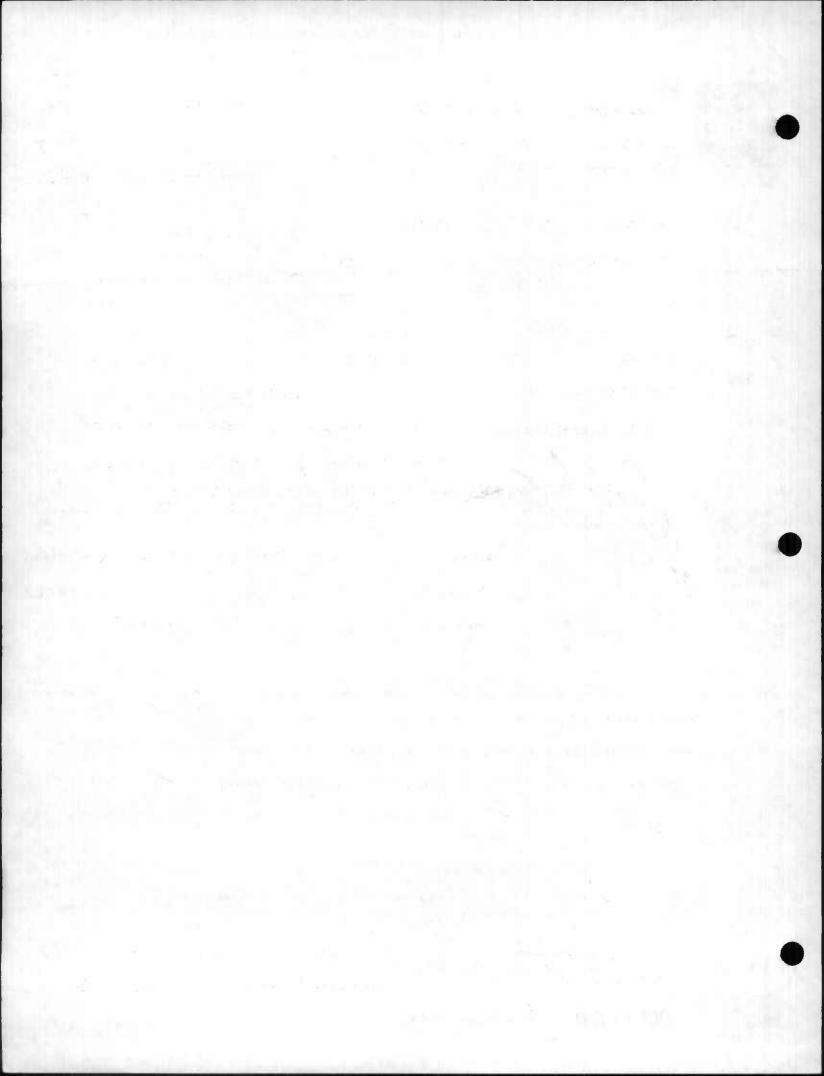
Dey, Year) State Registrar

32. Registrar's Signature was Davidson Randoge

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death **Physician** Month SHEPROD 10 am OCTOBER GLADY S 1897 10 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE-CITY BALTIMORD CITY MEDICAL CENTER LIBURTY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North 937 Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Days 244-76-6765 Director 59 November 26, 1937 Usuei Residenca of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f showed call Examiner must be notified at OCNYes 2□ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 3000 Reisterstown Road 21215 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 72 hours efter 1 Yes 2\No If Yes, Give Year or Detes: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 200No Specify. Specify: þ 3€XWidowed 4 □ Divorced Black nd 2 should be filed within 72 hour aith end Mentel Hyglene.
27 Is marked other than "natural r traumatic event, the Medical E. Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Years 17. Father's Name (First, Middle, Last) N/A Homemaker Her own Home 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health end Mentel I int: If item 27 is marked of Jack Dickerson Annie Mae Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health el Important: If item 27 Is any injury or other tra-Baltimore, MD 21215 Pearlie Sherrod-Dau 3000 Reisterstown Rd
20b. Placa of Disposition (Name of
cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) Sherrod Cemetery 10/19/97 Wayne County, NC 21. Signature of Funeral Bervica 22. Name and Address of Facility Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Catonsville, MD List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medicai Immediate Cause (Final RESPIRATORY DISTRESS SYNDROME ( disease or condition resulting In death) Examiner Dua to (or as a consequenca of) Examiner NECROTIC BOWELL WEEK physician and the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Dua to (or es a consequence of): ARTERIO SCLEROTIC MSENSE USSCULAR TEMON. Box 68760 Physician/Medical that the death certificate be Due to (or as a consequence of) 80 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown - CORONARY MATERY DISENSE - PNEUMONIL. signed t Records, by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed REMM INDUFFICIENCY - CONGULOPATHY. CHADNIC ONFRENCHICK page 2 PULLIFICATION DISTRICT - PEPILE ULLER . COLONIC DIVERTICISMI 1 Yes 2000 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of of effer death.

I Director: After to by the funeral 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicide 24 hours Medicai 29a. Certifiar 1 Descritiying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) ulle 10 October 110/1997 D19057 30. Nama and address of years on pleted cause of death (Item 23a) (Type, Print) 2600 Liberty Hoights Ave BALTO, MD. CORRETI ELAYO MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month 11, Charles Earle Smith, Oct. 1997 Jr. 11:30 PM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Pickersgill Towson Baltimore If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Steta or Foraign Country) **Funeral** XGM 2□F 85 Yrs. 216-12-6021 Director 11-13-1911 California Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manylan Department of Health end Mental Hygiane.
Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinat must be notified at any Injury or other traumatic event, I'm Medical Examinat must be notified at 10d. Inside City Limits 1 ☐ Yes 2√7 No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 615 Chestnut Ave. 21204 USA 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yaer or Datas: WWII 1 ☐ Yes 2 ☑ No Specify: q Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Insurance Executive Insurance 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Charles Earle Smith Lutz Mary Howard 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State Zip Code) 2 1 2 0 1 19a. Informent's Name/Relationship (Type, Print) 201 N. Charles St., E. Philip Franke, III/ PA Suite 2000, Baltimore 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 1947 Baltimore, MD Funeral Service Licensee 22. Nama end Address of Fecility Henry W. Jenkins & Son 4905 York Rd., Baltimore, MD on the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Lung Concer 4 months Examiner Due to (or as e consequence of) sician and buriel-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): physician a Physician/Medical Due to (or as a consequance of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Yas 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending Natural Accident cupital or Ah.

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in by \*\* 1 ☐ Yes 2 ☐ No Vone investigation 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as stated.

2 Medical Exeminer: On the bests of examination and/or Investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and menner stated. 29a. Certifier Medical 29b. Signature and title of control 29c. Licensa numbar 29d. Data signed (Month, Day, Year) D25205 30. Name end eddress of person who compresed cause of death (Item 23e) (Type, Print) Anthony Riley, 6565 N. Charles St., Towson, MD 21204 MD 31. Date filed (Month, Dey, Year) State

**DHMH 16 Rev 6/95** 

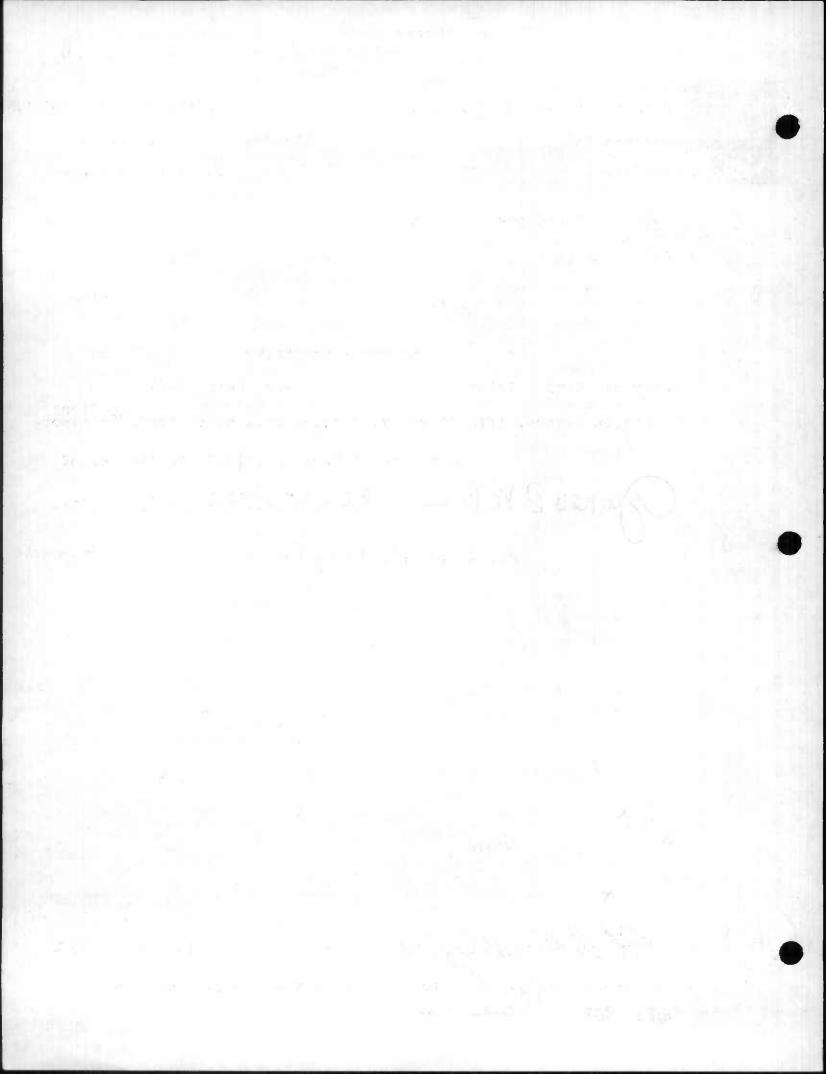
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State of Maryland / Department of Health and Mental Hygiene 9 7

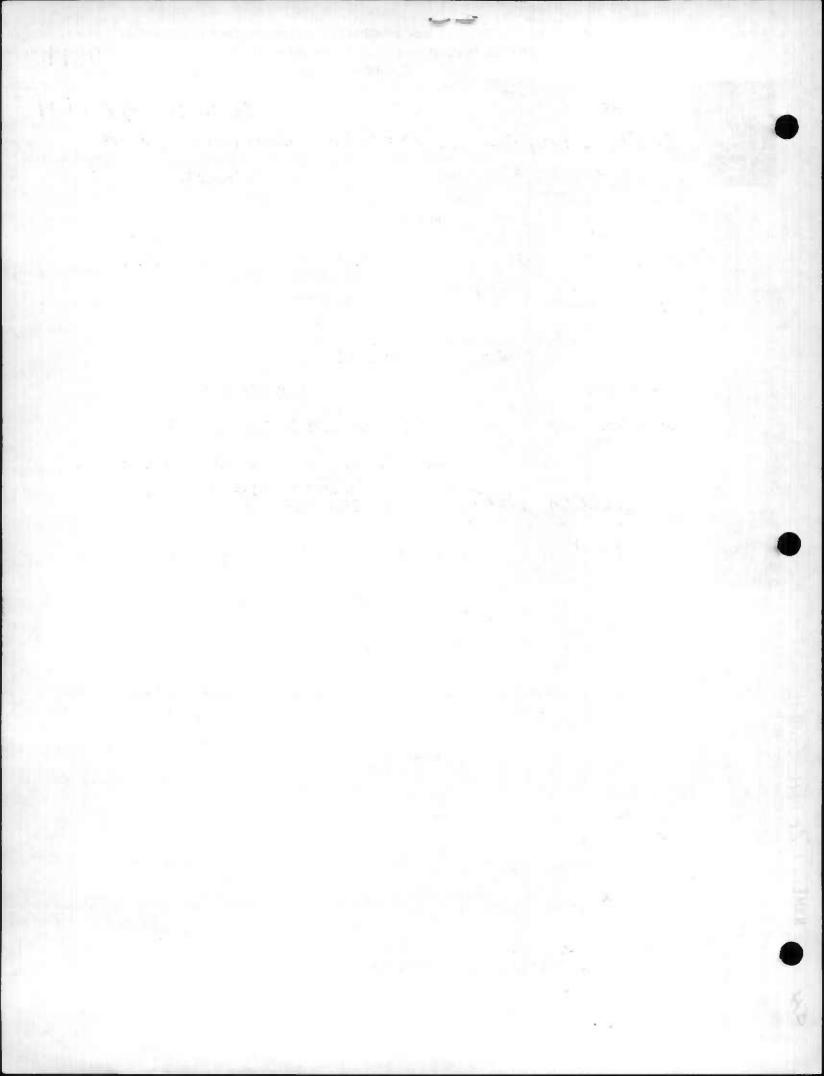
Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death **Physician IZETTA** SMITH Ctober Lo. 1997 /Medicai 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 900 Catow ALTIME BALTIMORE HONES HOSPITAL If Under 1 Yaer | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign Country) **Funeral** Days 10 M 2/0 F Director 212-14-0304 6-8-1912 MD Usuel Rasidance of Dacedeni 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, me Mooical Examinat must be notified as Director 1 TYVas 2 No N/A BALTIMORE 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda U.S.A. 14. Rece - Amarican Indien, Black, White, etc. 823 W. SARATOGA STREET Funeral 21201 12. Wes Decedant Evar in U,S Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1 Never Merried 2 Married 1 ☐ Yas 2 ☐ YNo If Yas, Giva X Yaar or Dates: Baltimore, Maryland 21215-0020 "naturaf', or 1 ☐ Yas 2 ☐ No þ Specify. 3 Widowed 4 □ Divorced AFR. AMERICAN Completed 18a. Decadant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry el Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) UNKNOWN UNKNOWN HOMEMAKER HOME 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maldan Surnama) permit. Peges 1 and 2 should be fi Department of Health and Mentel H Important: if item 27 is marked out any injury or other traumatic even once. Be 2 should be fi and Mentel H JAMES GRAY LOUVINIA GRAY 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) WILHELMINA GRAY 823 W. SARATOGA STREET BALTO, MD 21201 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☑ Burlal 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) KINGS MEM. PARK 10/11/97 RANDALLSTOWN MD 21. Signature of Funeral Sarvice Licansee 22. Nama end Addrass of Facility ESTEP BROTHERS FUNERAL HOME P.A. eul 1300 EUTAW PLACE BALTO. MD 21217 23a. Part1. Enter the disease, or complications that ceused the death. Do not antar the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each light. Approximata Intarval Batween Onset end Death **Physician** /Medical Immediate Causa (Final diseasa or condition rasulting In death) Examiner Examiner Sequantially list conditions, if eny, leeding to immadiate ceuse. Enter Undarlying Causa (Diseasa or Injury that Initiated avents rasulting in daath) Last physician end the buriel-tran ue to (or es a consequance of) Records, P.O. Box 68760. 10XLG Physician/Medical to (or as e consequenca of): 1000 Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably A Unknown 9 24b. Ware autopsy findings eveilable prior to complation of ceuse of daath? Completed 24a. Was an eutopsy performed? page 2 s 1 Yas 2 No 1 □ Yes 2 □ No Attending Physician: Be 25. Was cesa rafarrad to medicel axaminar? 26. Place of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) ertification: To 1 Yas MINO 1 ☐ Inpatient 2 ☐ € P/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury et Work? After 1 Natural 5 Panding death. Investigation 1 Yas 2 No 2 Accidant Director: / 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 Homicida 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the bast of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifian 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. Licansa number Bclokes 6, 1997 Solean us D40610 ST. AGNES HOSP. ER. 30. Name and addrass of person who complated ceusa of daeth (Itam 23a) (Type, Print) MOHAMMAN SALEEU 31. Data filad (Month, Day, Yaar) Julia Dandson-Rondelle State

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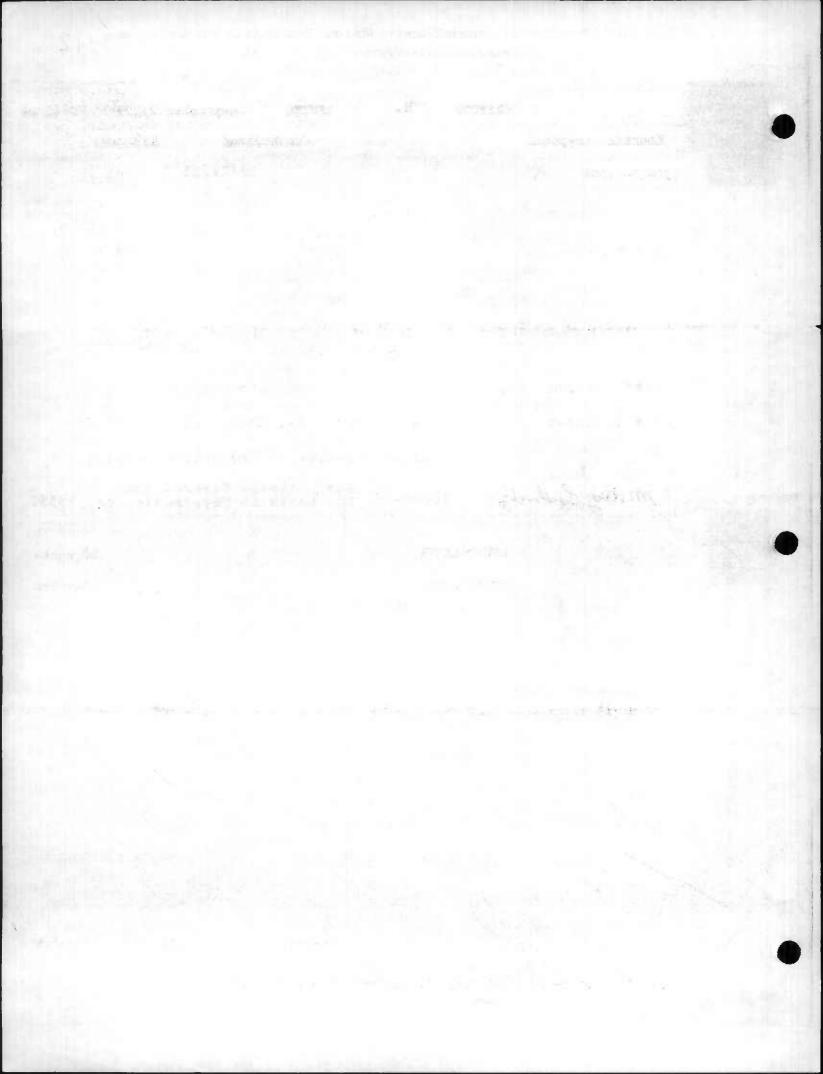
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eral ctor	1	35-24-5775	6. Sex 1 ☐ M 2 X F	6 Age (In yrs	s. last birthday, 9 Yrs.		Days	If Undar Hours		8. Date of Birth (Month, Day) Aug. 18	, 1928	9. Birthpi Coun Mass	laca (Stata or Foreign try) sachuset
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Month **Physician** CARL TAYLOR 0500 10 /Medical 4a. Facility Nama (If not institution, give street end number)
EVERGREEN NURSING HOME 4c County of Death 4b. City, Town, or Location of Chath **Examiner** Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Yaar) APR 9, 191 5. Social Security Number 3ex 1□M 2□F 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days 225-20-0724 81 Yrs. Director Virginia Usuel Rasidance of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, if a Medical Exercise martice contractions once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☐ No Director Anne Arundel Millersville 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 8351 Williamstown Drive 21108 USA Funeral 12. Wes Decedant Evar in U.S. Was Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, White, atc. Armed Forces?

1 ☐ Yas 2 ☐ No
If Yas, Give 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Disabled N/A 17. Father's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be George W. Taylor Gertrude B. Greenwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Louise C. Phelps/Niece 8351 Williamstown Dr. Millersville, MD21108 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 X Crametion 3 ☐ Ramovai from State Metro Crematory, Inc. 10/13/97 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, MD 32. Name and Addrass of Facility Stallings Funeral Home, P.A. 3111 Mountain Rd. 23a. Partí. Entar the diseasa, or complications that causad tha daeth. Do not anter tha mode of dying, such as cerdiac or raspiratory arrast, shock, or heart failura. List only one ceusa on each lina. Pasadena, MD 21122 Approximeta Intarvel Batwaan Onset end Death **Physician** ACCIDENTO /Medical immediata Cause (Final MEBROUASC disaasa or condition rasulting in daath) Examiner Examiner physician end s the buriel-transit The law requires that the death certificete be executed Saquentially list conditions, if eny, laading to immediata causa. Enter Underlying Cause (Diseasa or injury that initiated evants rasulting in deeth) Last Dua to (or as a consequence of) Physician/Medical Due to (or as e consequence of) esn jo Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, ρ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? s certificate hes t 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was cese referred to medical examiner? Be 26. Placa of Death (Check only ona) Othar: 2 1 Yes 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. injury at Work? 27. Manner of Daath 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred Certification: 28b. Tima of Natural 2 Accident 5 Panding miller death. 1 Yes 2 No invastigation the 6 Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homicida Activing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceusa(s) and manner as stated.

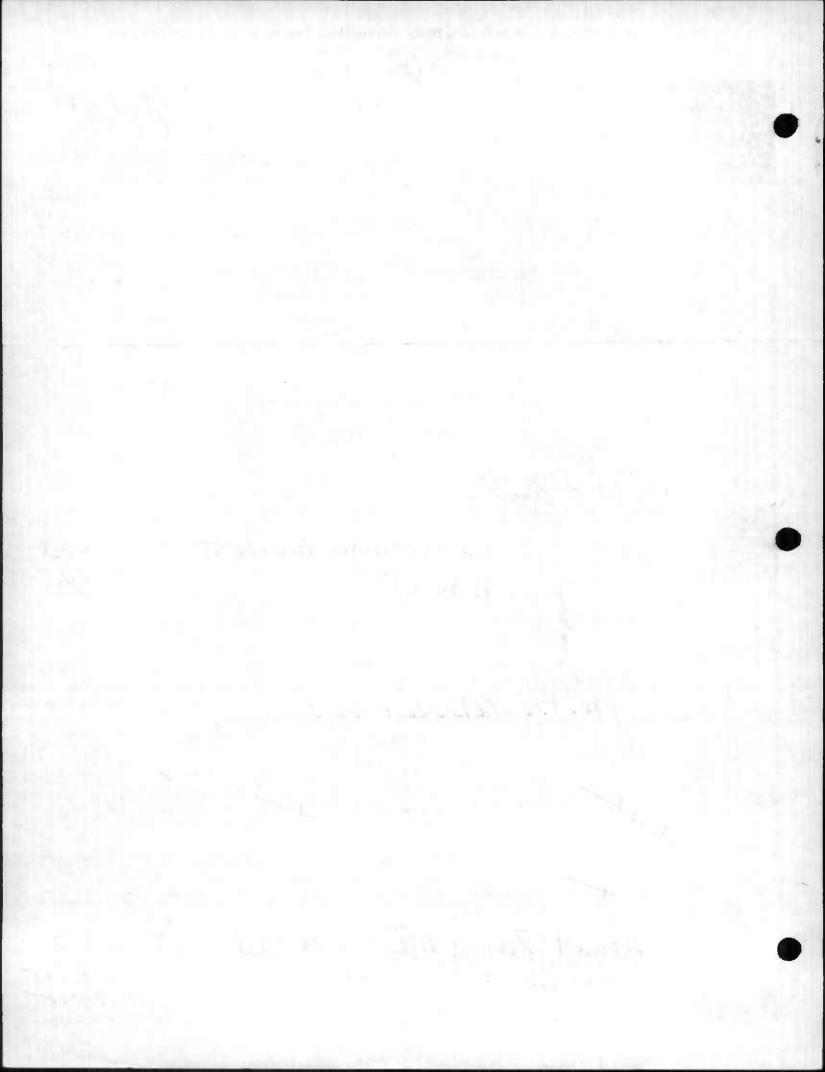
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. 29a. Cartifian 29b. Signature and tile of certifier 29c Licensa number 29d. Date signed (Month, Day, Year) and addrass of person who complated ceusa of daath (Itam 25a) (Type, Print)

GREEN MET ND PIKESULLE

State Registrar ed (Month, Day, Year)

32. Registrar's Signatura

Julia Davidson



State of Maryland / Department of Health and Mental Hygiene

Gertificate of Death

					Ce	ertifica	ite of	Death	1	Reg. No.	1 3	0915	
Physician	_	1. Decedent's Name (First, Middle, Les						6	2. Date of D	eath Day	Year	3. Time of Deatl	
/Medical	ŀ		yer-J	FNK	11/12				Octob		1997	4:20A	
Examiner		4e. Facility Name (If not institution, give Church Home H	ospital			-1-22221		Baltin			nty of Death	1 60	
Funeral Director		5. Sociel Security Number 6. Sec. 214-34-6818 11  Usual Residence of Decedent		e (In yrs. iest 9	birthdey Yrs.	Months Months	er 1 Year Days		(Month, L	irth Dey, Year) 13-38	9. Birth	place (Stete or Fore ntry) VA	
MOI 18		10a. State 10b. County		10c. City, T	own or L	ocation						10d. tnside City Lim	
tor ot	2	Md. NA		Balt	imo	re							
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by F	2	11. Maritel Status  1 □ Never Meπied 2 ☒ Maπled  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Wes Dec if Yes, sp	2.0	Hispanic Origin? oan, Mexican, Pue Specify:	(Specify Yes or Norto Rican, etc.)		14. Race - American Indian, Bleck, White, etc. Specify: Black		
orcar orcar	erec	15. Decedent's Edi (Specify only highest grad							odkina	16b. Kind of	Business/In	dustry	
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t: If tem y or offil	1	Mathod of Disposition  NGBurial 2 ☐ Cremation 3 ☐ F  4 ☐ Conation 5 ☐ Other (Specify)	Removal from State		etery, cre	emetory or	other ple	tery 1	Dete	20c. Location		own, State	
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Certifica		3 Sulcide 6 Could not be determined	28e. Place of inju building, etc.	ry - At home, (Specify)	farm, st	farm, street, factory, office  28f. Location (Street end Number or Rura City or Town, Stete)						al Route Number,	
dical											tated. the cause(s)		
To the comple		29b. Signature end title of certifier				29	c. Licen:	se number	29d. Dete signed (Month, Dey, Year)				
		In orbits				D 46893 Oct 9th 1997							
\	3	10. Name end address of person who co	mpleted cause of de	eath (Item 236				the He		d top	e, Mc	3. 21231	
State	3	11. Date filed (Month, Dey, Year)	132 Regierra	r's Signator	inder	2							

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Anna J. Thiess 12, 1997 **October** 4:00 am 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 3317 Foster Avenue Baltimore n/a 5. Social Security Number If Undar 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 8-10-1916 7. Age (In yrs. lest birthday) Birthplaca (Steta or Foreign Country) 1□M 200F Months Days Hours 214-12-2162 81 Yrs. Baltimore, MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits n/a Baltimore 1XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 3317 Foster Avenue USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ②No If Yes, Give 1 ☐ Yes 2 No Specify: White Specify: 3 Widowad 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilega (1-4or 5+) C & P Telephone Co. Telephone Operator 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Genevieve Beran Frederick Diller 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 642 S. Potomac St. Baltimore, MAryland 21224 Joan Lipsitz 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other plece) 1 XBuriai 2 ☐ Cramation 3 ☐ Removal from State Sacred Heart of Jesus 10/15/97 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Hm 21. Signature of Funeral Service Licensee 263 S. Conkling St. Baltimore, Maryland 21224 Zannero ar 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 511/1010 Due to (or as a consequence of) Sequentially list conditions, if any, laading to Immediate ceuse. Enter Underlying Cause (Diseasa or injury that initiated events resulting In death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? 3 probably 4 □ Unknown 1 Yss 2 No 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Yeer)

Examiner physician end s the buriel-transit requires that the death certificete be executed Records, P.O. Box 68760. ettending | USB 88 by signed t peed The lew hes page 2 certificate Division of Vital this After t the Hospital or Attending within 24 hours efter death. To the Funerel Director: Af completely filled in by the fu

**Physician** 

/Medical

Examiner

MD

Director

Funeral

à

Completed

Be

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**Funeral** 

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examines must be notified at

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"natural"

permit. Pages 1 end 2 should be tilt Department of Heelth and Mentel Hy Important: if Item 27 Is marked oth eny injury or other traumatic even

**Physician** 

/Medicai

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filed within 72 Hygiene.

Baltimore, Maryland 21215-0020

Exam Physician/Medical þ Completed Be 10 Certification: Medicai

6 Could not be determined

3 ☐ Suicide

29a. Certifier (Check only

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature-and title of certifier 29c. License number completed ceuse of death (item 23a) (Type, Print) Toper. 506 31. Date filed (Month, Day, Yeer)

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

State Registrar DHE H 6 Rey 5/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

**Physician** /Medical Examiner

3. Time of Deeth 2025PM

10d. Inside City Limits

Approximate Interval Bety Onset and Death

1 ☐ Yes 3 ☐ No

**Funeral** 

Director the Maryland 28a-f show ŏ

the Medical Examiner must be notified at Itеms 23a filed within 72 hours after ö "natural", I Hygiene. h and Mental F 2 Pages 1 and 2 should

21215-0020

Baltimore, Maryland

**Physician** /Medical Examiner

If item 27

other

ò Department of Important: If any Injury or once.

pue The law requires that the death certificete be execu Box ettending P.O. s been signed by t Records, certificate Division of Vital Physician: this Affer Attending efter death. in by t ò 24 hours

1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Month Albert P. Tomago, Jr.
4a. Fecility Name (If not institution, give street end number) OCTOBER 01, 1997 4b. City, Town, or Location of Death 4c. County of Death ROUTE 26 EAST OF BERKLEY DRIVE ELDERSBURG CARROLL COUNTY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth Birthpiace (State or Foreign
Country) **30**5M 2□ F Months Days Hours Min 213-70-5079 Yrs. July 22, 1955 West Virginia Usual Residence of Decadent 10a. State 10b. County 10c. City. Town or Location Director Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9805 Bethesda Church Road 20872 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 222No if Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married 1 Yes 20 No Specify: White by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15 Decadent's Education 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) landscaper self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Albert Paul Torrego, Sr. Jacqueline Margaret Tasker 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9805 Bethesda Church Road, Damascus Maryland, 20872 Ms. Nancy Ann Holsinger (scouse) 20a. Method of Disposition 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Buriai 2 Cremation 3 Removel from State 060ct.97 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Memorial Gdn. 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediete Ceuse (Finei Multiple Injuries disease or condition resulting in death) Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Physician/Medicai Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 12 Yes 2 No Be 25. Wes case reterred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Naturel Injury 1 Yes 2. Accident

1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 MOther (Specify) AT SCENE 28d. Describe how injury occurred 1942 10-1-97 Struck by automobile 281. Location (Street and Number or Rurel Boyte Number, City or Town, Stete) Route 36 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 5 treet

Carroll County, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and mariner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a, Certifier

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

O.C.M.E.

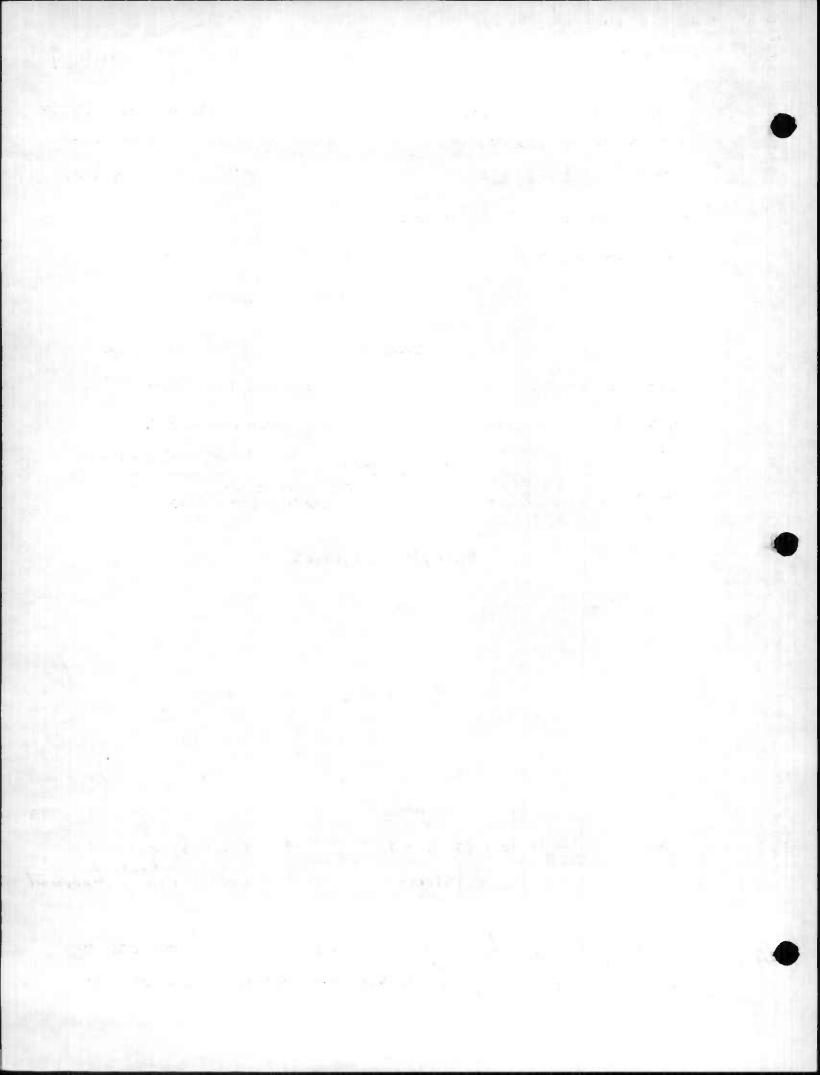
OCTOBER 02, 1997

Stephen S. Radeniz, MD 111 Penn Street, Baltimore, Maryland 21201

OCT 1 4 1997 State Registrar

Medical

Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death **Physician** Month CONSTANCE MOZIMOHT her Octo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5514 ELDERON AVENUE BALTIMORE CITY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplaca (Stata or Foreign Country)
NEW YORK 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F Months 21634447 59 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23e or 28a-f show traumatic event, tre Meoical Examiner must be notified at 10d. Inside City Limits MYes 2□No Director MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5514 ELDERON AVENUE 21215 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Ricen, atc.) Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours effer of Deperment of Health and Mental Hygiene.

Important: if Item 27 ia marked other than "natural", or Item any Injury or other traumatic event, the Medical Exercises once. 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SINAI HOSPITAL R.N. NURSE 12yrs 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) JOHNNIE LAW HOGGARD MAMMIE LEE HOGGARD 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 5514 Elderon Avenue, Baltimore, Maryland 21215 Woodrow B. Thompson, Jr/Husband 20b. Place of Disposition (Nama of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Kurial 2 ☐ Cramation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VETERAN 10-20 OWINGS MILLS, MARYLAND 21. Signalure of Foreral Service Licensus 22. Name and Address of Facility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 23a. Part1. Enter the disease of employees shock, or heart failure. List on a calions that caused the death. Do not entar the mode of dylng, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel arion disease or condition resulting in death) Examiner Examiner thet the death certificate be executed physician and s the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical the Due to (or as a consaquanca of): ettending | P.O. Part If. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. been signed by the should be detached 23b. Did tobecco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of ceusa of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 1 ☐ Yes 2 No Division of Vital the Hospital or Attending Physician: in 24 hours efter death. The Funeral Director: After this certifical hipletely filled in by the funeral director, it 25. Was cese referred to medical examinar? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigation Accident 3 ☐ Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signature and titla of certifian 29c. Licansa number 29d. Date signed (Month, Day, Year)

BOLTIMORE, MARYLAND, 21215

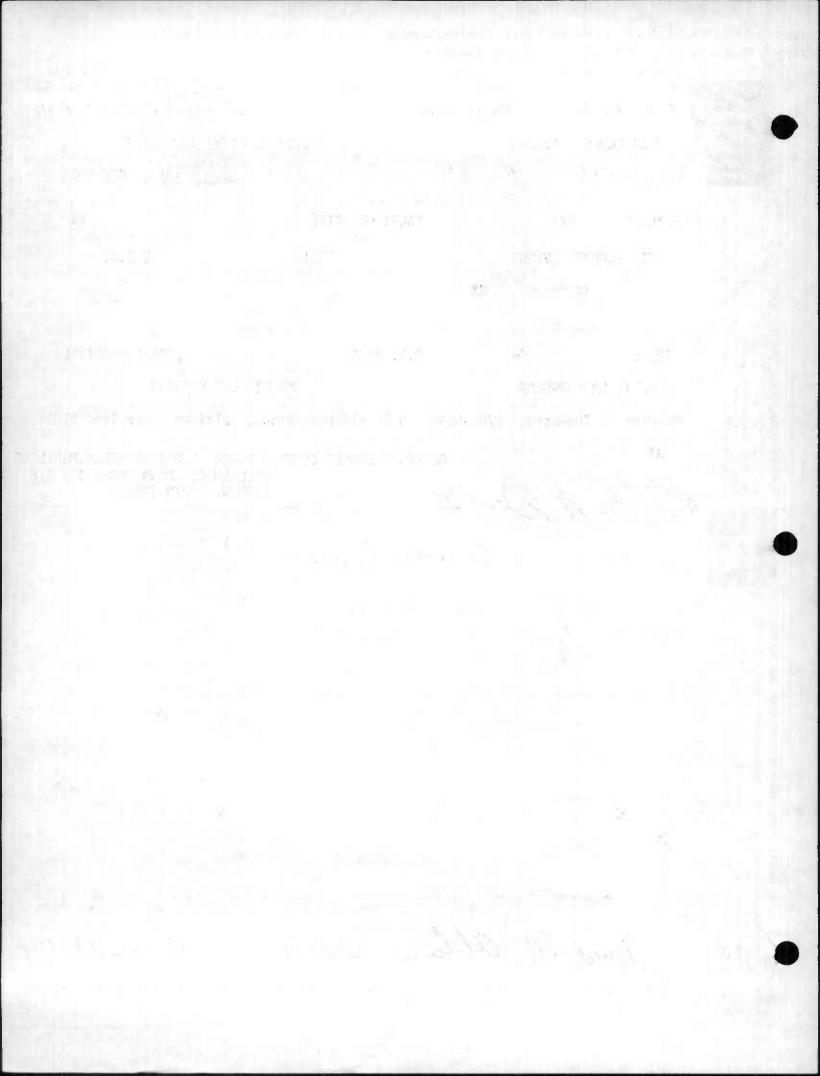
State Registrar 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

TROW

31. Date filed (Month, Day, Year) OCT 141997

BCLVEDORY SUITE

SUITE 206



CI TARIVAL VITAICONI

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Physician		rt I,II 27 1. Decedent's Ner C]		lle, Last)		son,	Jr.					2. Date of De Month OCTOBE		eth 3. 1		
/Medicai Examiner	ı	4a. Fecility Nama UNION 1				er)					4b. City, Town, or Location of De BALTIMORE			ath 4c. County of Death		
Funerai Director		5. Social Sacurity 216-62-	Number	6. Sex	7.	Aga (In yrs. 42	last birthda Yrs.	y) If Under Months	1 Yaar Days	If Undar		8. Data of Bi (Month, Di 10-20	rth ay, Year) 0-54	9. Birthi	place (State or Foreigntry) MD.	
28a-f show confed at		Usual Residence 10a. Stete Md.	of Decedent 10b. County NA				y. Town or								10d. Insida City Limit 1 DWes 2 □ N	
r items 23s or 28s-f shorter must be notified at		10e. Street and No. 3306 I		Aven	iue	10f. Zip Co				213	Е		10g. Citlzen	of What Cou	ntry?	
al', or items		1 Never Married 2 Married 1 Yes 2 No If Yas, Give Yaar or Dates:						3. Was Deced If Yes, spec		Black						
Hygiene. wher than "natural", ant, in wedge Ex		15. Decedent's 8 (Specify only highast gi Elementary/Secondary (0-12) GED			npleted) college (1-4	or 5+)		cedent's Usua ve kind of wo DO NOT u			st of work	ing	alto.			
d off		17. Fether's Neme		E.	Vi	snon,				Err	nest		Als	ton		
27 Is me		19a. Informant's Peggy	Α.	ship <i>(Type, P</i>			19b Mailing Address (Street and Number or Rural Route Number, City or Town, State 3306 Dudley Avenue Baltimore, Ma						, Mar	yland		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		TRunial O Commation 2 Demoust from Chate					20b. Place of Disposition (Name of cemetery, cremetory or other place) MARYLAND Date  Garrison Forest VA Cem. 10-20-97 - Owings									
Depertment: Important: any Injury once.		21. Signature of F	uneral Service	Licenses	PA-)		22. Name and Address of Facility Baltimore, Maryland 2. WM.C.MArch FH 1101 E. North Avenue									
hysician Medical xaminer		23a. Part1. Enter shock, or he Immediate Ceuse disease or conditi resulting in death)	(Final	r complication t only one ce		ONTINE	HEMORR	HAGE		ing, such as	cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death	
b					Due to (or as a consequence ot):											

Sequentielly list conditions, if any, leading to immediate ceuse. Entar Underlying Causa (Disease or Injury that initiated events resulting in deeth) Last

Examir

Physician/Medical

p

Be Completed

Medical Certification: To

CHRONIC NARCOTISM

Due to (or as e consequence of):

Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably Unknown

24e. Wes en eutopsy performed?

24b. Were autopsy findings available prior to completion of ceuse of death?

1 Yes 2 No Yes 2□ No

25. Was cese referred to medical examiner? 1XYes 2□ No

investigation

28a. Deta of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatlent > DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 XXNatural

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and plece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

O.C.M.E

OCTOBER 11,1997

to us Iss. Registrar's Signature fundates.

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

26. Place of Deeth (Check only one)

State Registrar

444.

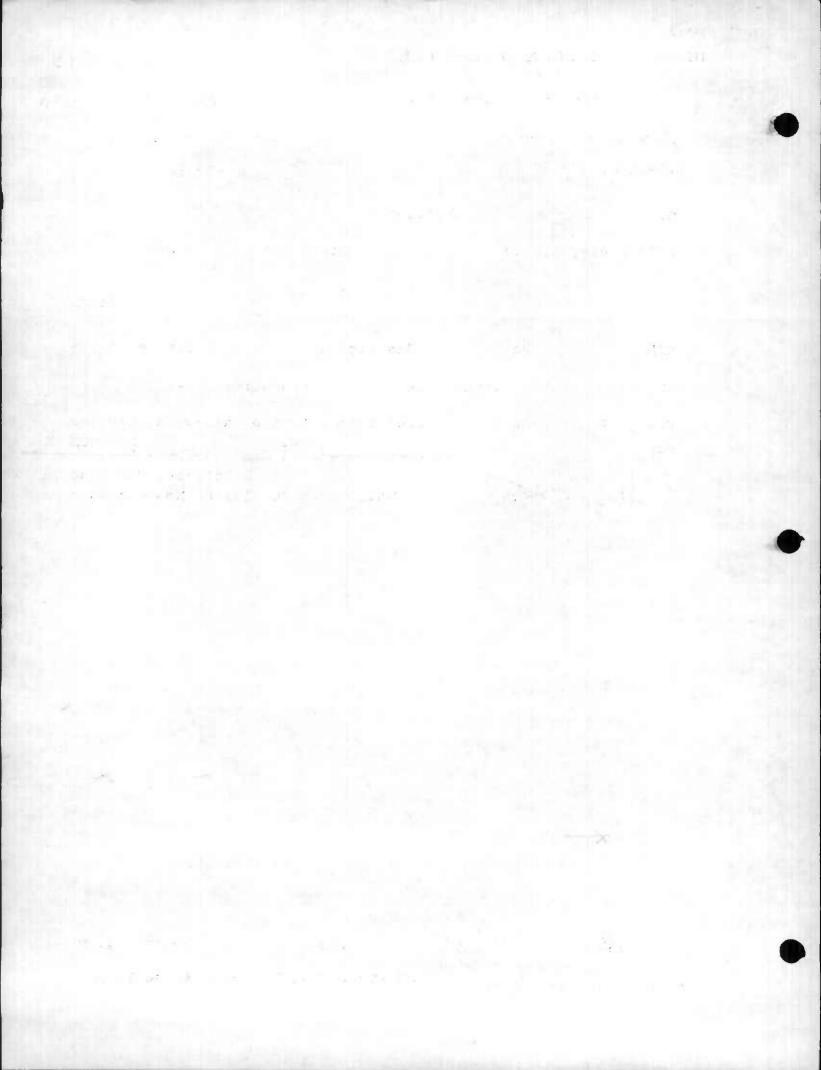
To the Hospital or Attending Physician: The law requires that the death certificate be executed primin 24 hours after death.

To after Funeral Director: After this certificeta has been signed by the attendion above.

eta has been signe paga 2 should be

In by the

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Yaar **Physician** 199 /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Ba MMOR 5. Social Security Number 213-80-36 6. Sex 1 M 2 □ F If Undar 1 Yaar If Under 24 Hrs. (In yrs. last birthday) **Funeral** Months Deys Hours Director Usual Rasidanca of Dacedent Peges 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health end Mentel Hygiene.
snt: If Item 27 is marked other than "natural", or items 23a or 28s-f show 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner issust be incitified at 1 Yas 2 No Directo Maryland mor 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Funeral Was Decedant Evar in U.S. Armad Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Merital Status 12 1 Navar Married 2 Married 1 Yes 2 No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Hmerican Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 0 Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Surname) Be 10 (Brother 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town injury or other 20b. Placa of Disposition (Nama of cemptary, pramatory or other place) 20e. Mathod of Disposition Qata 20c. Location City or Town, Stata 1 Burial 2 Crametion 3 DRamoval from State Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Sarvied Licenses 22. Name end Addrass of Facility Ba SP ice North Ave Z ture. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Duatory Examiner Qua to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the bunel-transi Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daeth) Last Dua to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or es e consequance of) as use signed by the ette Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Completed peeu pege 2 s After this certificate 1 🗆 Yas To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 20 1 Inpatiant 2 ER/Outpatient 3 DOA funerel 28c. Injury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of Certification: 1 Natural 2 Accidant 5 Panding invastigation 1 Yas 2 No 3 Suicide 6 Could not be 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homleida Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and menner stated. Medicai 29a. Cartifian 29b. Signetura end titla of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Nama and addrass of parson who complated cause of death (Itam 23a) (Type, Print) ent 31. Date filed (Month, Day, Year) 14 1997 32, Ragistrer's Signature What Day dron-handele State Registrar

97-5823-510 B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 7 3 0 9 2 1

GREGORY	WA	TKINS		Certificate	of Death	Re	eg. No.	00	761
Physic	ion	1. Decedent's Name (First, Middle, La	st)	117.		2. Date of Deat Month	h	Yeer 3.	Time of Deeth
Physic /Med		Gregory	Wa	tkins		OCT.	10, 199		203 PM
Exam		4e. Fecility Neme (I) not institution, give	re street and number)		4b. Cify, Town, or	Location of Death	4c. County o	f Pelath	
		1900 BRADDISH A			BALTIMO			VIA	
Funera Director	_	5. Social Security Number 6. S 220-64-9371 Usual Residence of Decedent	M 2□ F	Yrs. If Under 1 Months I	Yeer If Under 24 Hrs Days Hours Min		1956 1	9. Birthplace Country)	(State or Foreig
5-UUZU 72 hours efter death with the Maryland naturel, or frems 23s or 28s-f show	o.	10a. State 10b. County	A 10c. C	ity, Town or Location	ro				nside City Limits
ire, Maryland 21215-0020 s 1 end 2 should be filed within 72 hours efter death with the Maryla f Health and Mentel Hygiene. If Health and Mentel Hygiene. Item 27 is marked other than "natural", or frems 23s or 28s-1 show other treumstic event, the Medical Event and the most be not fred at	Funeral Director	10e. Street and Number		10f. Zip Ci	ode	10	0g. Citizen of Wi		X
23a c	raiD	2217 KOK	o Lane	d	2/2/6		115	SA	
iteme	une	11. Maritel Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13. Was Decader If Yes, specify	nt of Hispenic Origin? ( Cuben, Mexican, Pue	Specify Yes or No- to Rican, etc.)		- American Ir , White, etc.	idien,
irs effe	by F	1 Never Married 2 Married 3 Widowed 4 Divorcad	1 Yes 2 No If Yes, Give Year or Dates:	1□ Yes 20			Specify:	-1	rK
thin 72 hours eff e.  an "natural", or	ted	15. Decedent's E	ducation	16e. Decedent's Usual C	Occupetion	T	16b. Kind of Bus	iness/Industr	~   \
ithin 7	Completed	(Specify only highest grade) Elementary/Specondary (0-12)	College (1-4or 5+)	life. DO NOT use	done during most of wo	orking	1.	1	1.
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2 should be and Mentel a marked o	2	19a. Informant's Name/Relationship (	Typo, Print) (mother	19b. Meiling Address /S	Street end Number or F	ural Route Number,	City or Town, S	Itale, Zip Cod	(e)
is 1 end 2 so of Health ar Rem 27 la other trau		Mrs. Bertha	Watkins	2217 Kg	Ko Lan	e Ba	Ho. M	d.21	1216
it of He		20a. Method of Disposition 1 ⊠ Buriel 2 □ Cremation 3 □		Place of Disposition (Name certifier, cremetory) or other	of er place)	1 1	20c. Location - C	ity or Town,	State
semit. Pages 1 er Department of Hea mportant: If Item; nny Injury or other page.		4 Donetion 5 Other (Specif		Arbutu	5	10/16/97	Balt	o, Co	, Md.
permit. Pages Department of Important: If It any Injury or once.		21. Signature of Funerel Service Urger	isee PD	22. Name end	Address of Facility	SS FIL	noral	Hor	ne.
- 40260	L	yoseph	L. Ku	11 3222	W. Nort	h Ave.	Balt	o. Md	.2121
		23e. Pert / Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not enter the mode of	of dying, such es cardia	c or respiratory erre	est,	Inte	roximete rval Between set and Deeth
Physician /Medical		Immediate Ceuse (Final	(° 0 1	110 01	0 , 0	CI			of and Debtin
Examiner		diseese or condition resulting in death)		or as e consequenca of):	Dick of	Chest		1	
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by the	Physician		or mading to down but not to	John J I I I I I I I I I I I I I I I I I I	so given ar Pott i.		s 2 No		
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E ag						1 24	s 2 No	Yes Yes	s 2 No
Physician: The this certificate ral director, par	o Be	25. Was case referred to medical examiner?	Hospital:		Other:	ath (Check only one			
Phy this	H	Yes 2 No 27. Manner of Deeth	28a. Date of Injury	ER/Outpatient 3□ DOA 28b. Time of 28c.	4 Li Nursing	Home 5 Reside	4 34 3		
Attanding F or death. ector: After by the funer	ation	1 Naturel 5 Pending 2 Accident Investigation	(Month, Dey Year)	2156 PM	injury at Work? 1 ☐ Yes 2☑No	2 1900	Braddish		
무하는	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, fectory, o	ffice	28f. Location (Str City or Town	eet end Number	r or Rural Rou	ite Number,
To the Hospital or within 24 hours eftu to the Funeral Officempletely filled in	edicai C	29a. Certifier 1 CertifyIng Ph	ysician: To the best of my kno niner: On the basis of examina end manner stated.	owledge, death occurred et tation end/or investigation, in	the time, date and plec my opinion, deeth occ	a, and due to the ce urred et the time, da	use(s) end meni ite end pleca, en	ner es stated ad due to the	Ceuse(s)
to the	Me	29b. Signeture end title of cartifier		29c. L	icense number	29	d. Date signed	(Month, Dey,	Year)
1	1	1 Question 1	Chuker		D.C.M.E		OCT.	11, 19	197

111 Penn Street, Baltimore, Maryland 21201

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

State

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\*natural", or item

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7 Is marked other treumatic event, to

Department of Important: If eny Injury or once.

**Physician** 

/Medical

Examiner

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signed b

page 2 s certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, i

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Box 68760

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Records.

Vital

Division of

I Hygiene.

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by

Completed

Be

Examiner

Physician/Medicai

by

Completed

Be

Certification: To

Medical

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7

Certificate of Death	Reg. No.	
	2. Date of Death Month Day Year OCTOBER 04, 1997	3. Time of Deetl
4h City Town	or Location of Death 4a County of Dea	th

BALTIMORE CITY

JOHNS HOPKINS HOSPITAL PEDIATRIC E.R. 5. Social Security Number

WADELL

If Under 1 Year 7. Age (In yrs. last birthday) 1 M 2 F Yrs. 2 20

10c. City, Town or Location

if Under 24 Hrs 8. Date of Birth (Month, Day, Year) JUL.14,1997

9. Birthplace (State or Foreign MARYLAND

N/A MD.

BALTIMORE

10d. Inside City Limits Yes 2 No

10e. Street and Number

1017 DARLEY AVENUE

10b. County

21218 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

10f. Zip Code

10g. Citizen of What Country? U.S. OF A. 14. Raca - American Indian, Black, White, etc.

1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

DEONNA

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:

1 ☐ Yes 2 No Specify: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Specify: BLACK 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) N/A

College (1-4or 5+) N/A

NEVER EMPLOYED

17. Father's Name (First, Middle, Last)

LYNDON WADDELL

LINDA CLARK

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

LINDA CLARK (MOTHER)

1017 DARLEY AVE. 20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE, MARYLAND21218 20c. Location - City or Town, Stete

N/A

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

MT. ZION CEMETERY 10/11/97 22. Name and Address of Facility

BALTIMORE, MARYLAND

21. Signature of Exercise Service Licenses ENIS T. GWYNN

LEWIS T. GWYNN FUNERAL HOME

4517 PARK HEIGHTSAVE. BALTIMORE, MD. Approximate the mode of dying such as cardiac of respiratory arrest. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart fellure. List only one cause on each line. val Rei

tmmediate Ceuse (Finat disease or condition resulting in death)

CONGENITAL HEART DISEASE

Due to (or as a consequence of)

Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequenca of):

Due to (or as e consequenca of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was en eutopsy pertormed?

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No 1 Noves 2 No

25. Was case referred to medical examiner? 138 Yes 2 No

5 Pending

Investigation

6 Could not be determined

28a. Date of tnjury (Month, Day Year)

Hospitat: 1 ☐ Inpatient 2 M ER/Outpetient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

27. Manner of Death

XX Naturel

2 Accident

3 Suicide

4 | Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

O.C.M.E.

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

OCTOBER 05, 1997

30. Name and Who completed cause of death (Item 23a) (Type, Print)

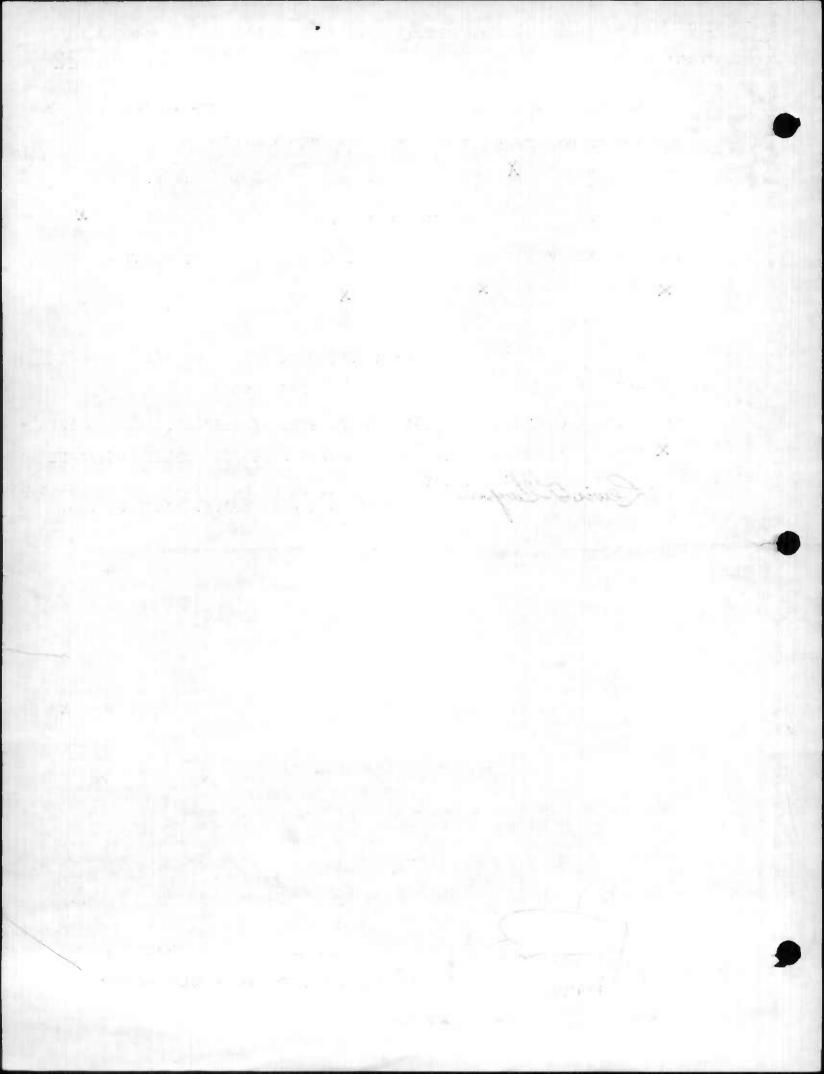
111 Penn Street, Baltimore, Maryland 21201

Day, Year) 31. Date filed (Month OCT

32. Registrar's Signature

State Registrar

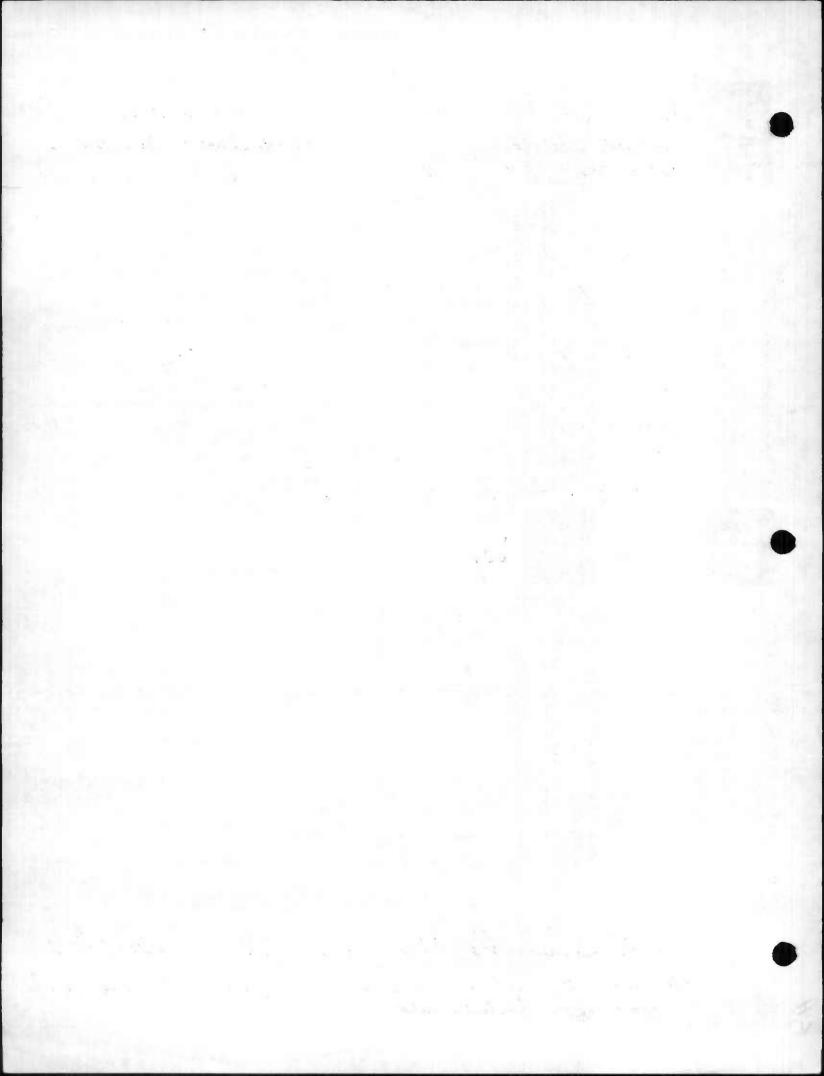
**DHMH 16 Ray 6/95** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant'a Nama (First, Middla, Last) 2. Deta of Death 3. Tima of Death **Physician** 30 PM 997 /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stown nesis Hercare If Undar 24 Hrs. Homer 7. Aga (In yrs. last birthday)
Yrs. If Undar 1 Yaar Birthplace (Stata or Foraign Country) 5. Social Security Number 6. Sax **Funeral** 10 M 20 F Months Days Hours 223.34.3507 Director Usuai Rasidance of Decedant with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor treumatic event, the Mourcal Examinal must be notified at 28a-f show 1 Yas 2 No Director Ma 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 12. Was Decedant Evar in U.S. Armed Forces? 1 — Yas 2 U No If Yas, Giva Yaar or 21227 5.4 102 Funeral Pages 1 and 2 should be filed within 72 hours after death 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1□ Yas 2XNo Specify. Black ģ 3 ☐ Widowed 4 ☐ Divorced Specify Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Hospital nd Mental Hyglene. marked other than Eiamantary/Secondary (0-12), Collaga (1-4or 5+) thgrade Nurse NA 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be end Mentai Corpreu a bella Cross P Walter 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) Randallstown, Md 21133 Department of Health important: If item 27 is any injury or other tre Haalth - Husband ourt taro a 20b. Place of Disposition (Nama bl cematary, crematory or other place 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 Buriai 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) butus Mem 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility 21215 Dalto, My 300 Wabast مه )0 23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximata intarval Between **Physician** /Medical Immediata Causa (Finel disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Entar Undarlying Ceuse (Diseese or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Dua to (or as a consequence of) attending p signed by the at Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 (No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to s need Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s il director, page 2 No 1 ☐ Yas 2 ☐ No after death.

Director: After this certifica 25. Was casa rafarred to medical examinar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28h Time of 28c. injury at Work? 1 Natural 2 Accidant 5 Panding 2 - No Invastigation 1 Yas 6 Could not be datarmined 3 Sulcida 28a. Place of injury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 3 4 Homicida To the Hospital or A within 24 hours aftar To the Funeral Director completaly filled in b 29e. Cartifiar (Check only one) 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner se stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29b. Signatura and titla of cedifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) daath (itam 23a) (Type, Print) 201 31. Data filed (Month, Dey, Year) State OCT 1 4 1997 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 7 30924

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AVENUE

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Physician/IM Be Completed by Medical Certification: To

The law requires that the death certi-

signed by the al

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director, t

Division of Vital Records, P.O. Box

Approximete Intarval Batween Onsat and Daath Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 427 Unknown 24b. Wara autopsy findings eveilabla prior to 24a. Was an autopsy complation of causa of death? 12 Yas 2 No 1 Yas 2□ No 25. Was case rafarred to medical axeminar? 26. Place of Deeth (Check only ona) Othar: 4 Nursing Homa XX Rasidance 6 Othar (Specify) XX Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Daath 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1XX Natural 1 Yas 2 No 2 Accidant 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

\*\*Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29a. Certifiar (Check only one)

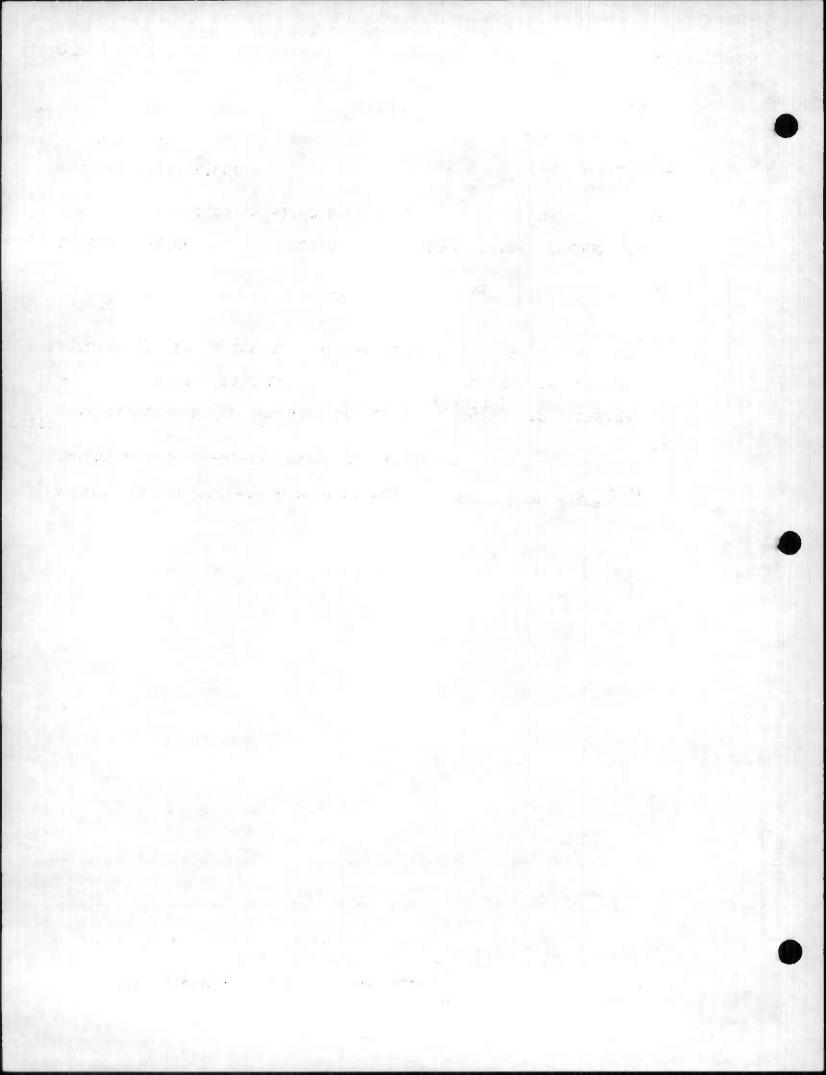
29b. Signetura and titla of cartifier

29c. Licansa number O.C.M.E

29d. Date signed (Month, Day, Year) OCT. 11, 1997

who complated cause of death (Item 23e) (Type, Print)

Radentz 111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month

October 4, 1997

10d. Inside City Limits

Approximete intarval Bet Onsat and Death

1 Yas W No

29d. Dete signed (Month, Day, Year)

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Myrtle Kathalene Wine

buniel-transit end physician Box 68760 The law requires that the death certificate be the attending for use es P.O. the 2 signed t Records, been : page 2 certificate Division of Vital

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etaly filled in by the funeral director, I 24 hours npletaly To the F within 2 To the F

4e. Fecility Nema (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia If Under 1 Yaar If Under 24 Hrs. Nonths Days Hours Min. March 7, 1926 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral 1□M 20KF 71 Yrs. Director 220-22-4903 Kentucky Usuei Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or frame 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Maryland Carrol1 Eldersburg 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 938 A Marimich Court 21784 death Funeral 11. Merital Status 12. Wes Decedant Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck White atc. 72 hours after 1 Never Married A Married 1 ☐ Yes 20 No If Yas, Give Year or Detes: altimore, Maryland 21215-0020 1□ Yas XX No Specify: White white Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiens Important: If Item 27 Is marked other than "n any Injury or other traumatic avant. Shear Magic Elementery/Secondary (0-12) College (1-4or 5+) beautician hairstylists, Inc. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Chester Ward Lucy Campbell 19a. Informant's Nema/Ralationship (Type, Print) 19b. Meiling Addrass (Streat end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Ralph Wine (spouse) 938 A Marimich Court, Eldersburg, Maryland 21784 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Date 1 Suriel 2 □ Cremetion 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cemetery Oct. 8,97 Ellicott City, Maryland 21. Signeture Funeral Service Licensee 22. Name end Address of Fecility Slack Funeral Home, P.A. Enter tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, or heert failure. List only one ceuse on each line. Physician ASPIRATION /Medical Immediata Cause (Finel diseesa or condition resulting in deeth) Examiner Examiner BARTAL COLONIC OBSTRU CTEON Sequentially list conditions, if any, leading to immadiete cause. Entar Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Dua to (or es e consequenca of): STONE IMPACTION Physician/Medical Dua to (or as a consequence of): POST OF ILEUS Part II. Other significent conditione contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contributa to the cause of death? SFUFRE CUPP 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware eutopsy findings aveileble prior to complation of cause of deeth? 24a. Was en eutopsy performed? Completed ASCHO Be 25. Was case referred to medical 26. Plece of Deeth (Check only ona) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Tes 27. Menger of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Panding 1 ☐ Yes 2 ☐ No Investigation 2 Accidant 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At homa, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicida 1 Certifying Phyelcian: To the best of my knowledge, daath occurred et the time, dete end pleca, end due to the cause(s) end menner as steted.
2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, deeth occurred et the time, date end pleca, end due to the causa(s) end mannar stated.

State Registrar

Medical

29a. Cartifier

29b. Signature end title of certifier

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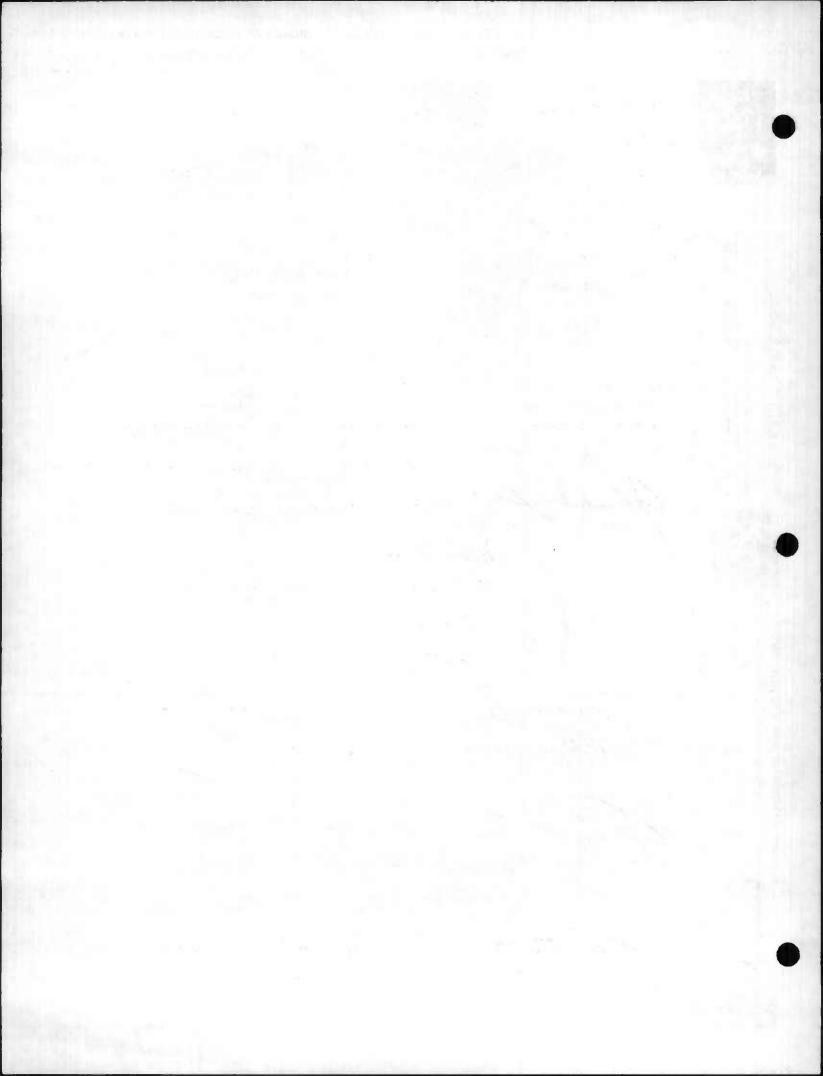
31. Dete filed (Month, Day, Yeer)

Julia Pagistrar's Signature Julia Paydon-Handall

e VORTULAMI

30. Neme end eddrass of person who completed causa of death (Item 23e) (Type, Print)

29c. Licanse number



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month WEINSTEIN OCTUBER 12 1977 243 PM MORMS /Medical 4a. Facility Name (If not Institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALTIMORE HOSPIML CENTER 7. Age (In yrs. lest birthdey) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 1997) | 1.3, 1 5. Social Security Number 9. Birthplace (Stete or Foreign **Funeral** M 2□ F Mass. 439-09-6242 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Md. Randallstown 1 Yes 2 XNo Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 荔 therms 23a 3722 Eastman Road 21133 USA Funeral Was Decadent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 215-0020 b by 3 Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Merchant Marines 11th Navigator 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Benjamin Weinstein Fannie (Unknown) 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Max Weinstein / Son 576 Manor Rd. Severna Park, Md. altimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State = 5 4 ☐ Donation 5 ☐ Other (Specify) 10-13-97 | Hampstead, Md. Carroll Cremations 21. Signeture of Funeral Servica Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, Md. Eline Funeral Home Ruce 23a. Part1. Enter the disease, or complications that caused the chill. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical MYOCARDIAL INFARCTION / HOUR Examiner Due to (or es a consequence of): Examiner YEARS DISENSE and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequença of) Physician/Medical Due to (or as a consequenca of): Box ( Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Minknown MELLITUS signe bed ρ Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? MELANDMA certificate 2/200 1 Tyes 2 □ No of Vital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Certification: To 1 Yes 2 40 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending Investigation Division 1 Netural 2 ☐ Accident after death.

Director: Aft
d in by the ful 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signeture and title of confifier 29c. License number 29d. Dete signed (Month, Day, Year) OCTOBER (2 199) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONTHUEST

32. Registrer's Signature

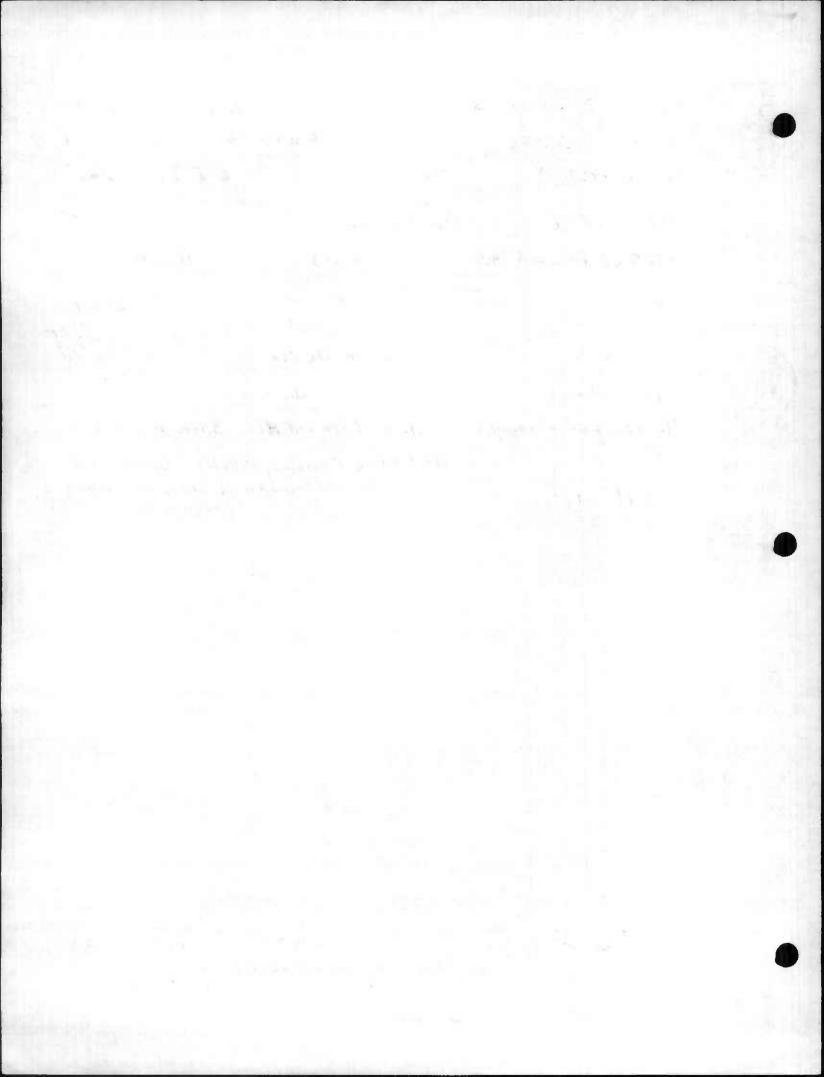
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31. Date filed (Month, Dey, Year)

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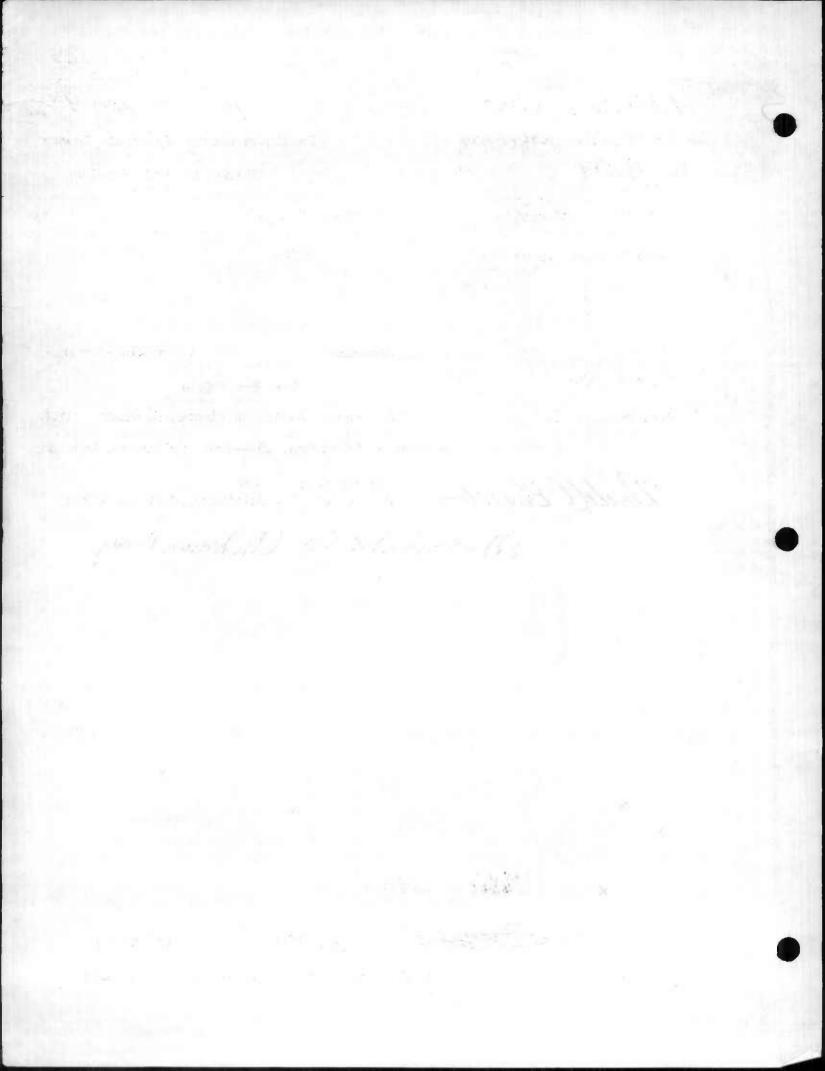
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4		30. Name and address of person who DAV () O - NY/	completed cause of dea		pe, Print) (3	O	n ers	MOM	1 2123	(		
Stat	e	31. Dete filed (Month, Dey, Year)	32. Registrer	's Signeture								



State of Maryland / Department of Health and Mental Hygien

Certificate of Death 1. Decedent's Name (First, Middle | Last) 2 Date of Death 3. Time of Death Month **Physician** 1 /Medical Nama (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gerjegs Baltimore County Baltimore County 7. Age (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 ☑ F Yrs. 84 Director Aug. 14,1913 | Maryland death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner main be notified at 1 ☐ Yes 2 No Maryland Baltimore Baltimore County Director 10e. Streel and Number 10f. Zip Code 10g. Citizan of What Country? USA 4601 Kenwood Avenue 21206 Funeral 14. Race - Amaricen Indian, Black, White, etc. 11. Maritai Status 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yes X☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puarto Rican, atc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1 ☐ Yes 2 KI No Specify: Aq. X Widowad 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ne any injury or other treumatic event, the Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 12 yrs. N/A Homemaker Homemaking-Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Clarence Kyle Mary Irene Kyle 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Margaret E. West 4601 Kenwood Avenue Baltimore, Maryland 20a. Mathod of Disposition 20b. Place of Disposition (Nama of 20c. Location - City or Town, State Gardens of Faith Cem. 10-9-1997 1 Burial 2 ☐ Cramation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner physician end the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the death certificate be Physician/Medical Due to (or as a consequence of): esn for deteched Part ii. Other significant conditions contributing to death but not resulting in the underfying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wera autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed peen hes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Wes case referred to medical examiner?
1 ☐ Yes 2 No 26. Piece of Deeth (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA this 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: After 1 Metural 5 Pending efter death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier ix Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated. 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10/8/97 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Zied K. Nirza 3007 E. Northern Pluy Baltimore, Mb 21214 Sulia Balldstores Floridall 31. Date filed (Month, Day, Year) 1 4 1997 001

Registrar

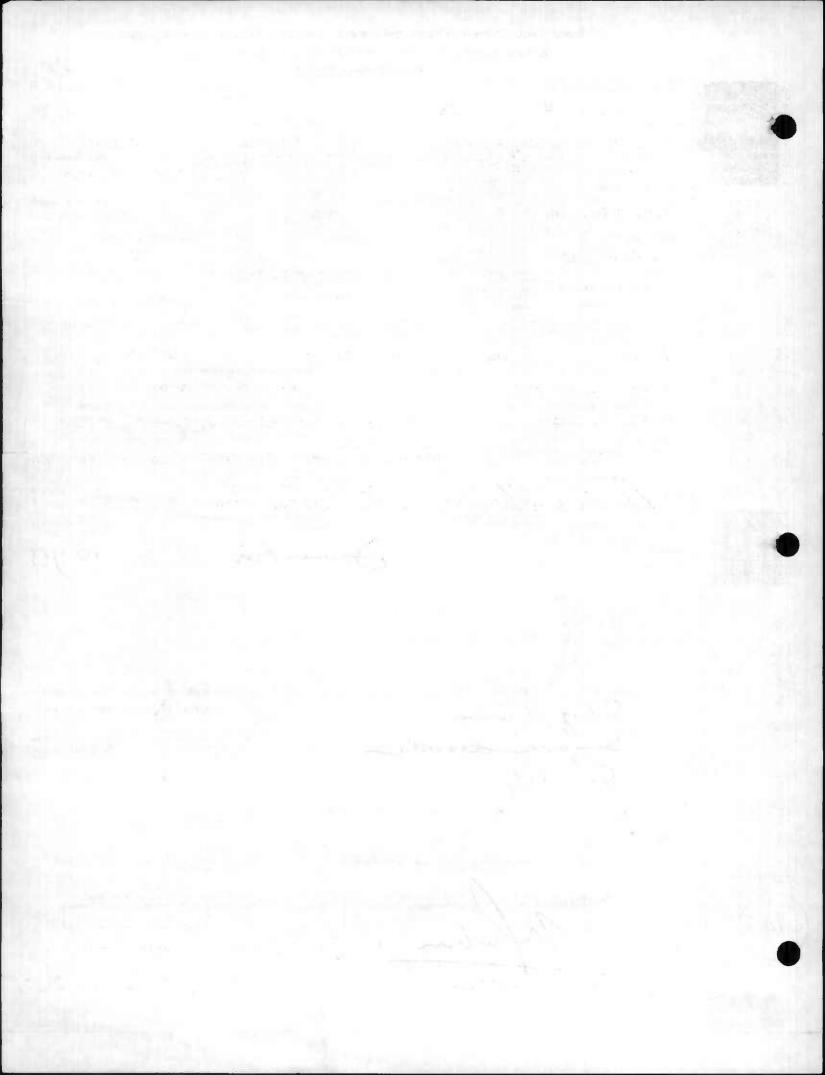


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Month 2 HELEN ZELLER Oct. 1997 4:23 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Franklin Square Hospital Center Baltimore Rosedale If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 2K F Yrs Oct. Director 219-32-B969 60 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. insida City Limits Item 27 is marked other than "natural", or Items 23s or 28s-4 show other traumetic event, the Medical Examiner must be notified at Maryland Baltimore Essex 1 ☐ Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Judy Wood Lane 21221 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - Americen Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) end 2 should be filed within 72 hours efter of eelth end Mental Hygiene. n 27 le merked other than "natural", or iten 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify p Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 yrs. Head Cashier Banking N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Bernard William Jones Helen Marie Bruno 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) permit. Peges 1 end 2:
Department of Heelth er
Important: if Item 27 la
eny Injury or other trau Charles J. Zeller 3 Judy Wood Lane Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Locetion - City or Town, State Date 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 10-6-1997 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that ceused the daeth. Do not enter the mode of dylng, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Deeth **Physician** Immediate Ceusa (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner physician and the burief-transit certificate be executed Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaasa or Injury Due to (or as a consequence of) Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 40 use a 20 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of ceuse of death? Completed peen page 2 Sec t ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Magner of De 28d. Describe how injury occurred 28c. Injury at Work? After I or Attanding in after death. Natural 5 Pending after death. Director: Af 1[]Yes 2[]No investigation 2 Accident 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the last of my knowledga, daath occurred at the time, date and place, and due to the ceusa(s) and mannar as stated.

2 Medical Examiner: On the case of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifier Medical 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 326 inth (Item 23a) (Type, Print) FSSEX Medical Center 21221

DHMH 16 Rev 6/95

State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daeth 3. Tima of Death Month Eptember -CON 26,1997 0030 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Days Hours 1 M 2□ F 214-36-7363 Yrs. Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Worcester 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8 6 TIN 12. Was Dacadent Ever In U.S. Armed Forces? 1 ☐ Yas 2 0 No If Yas, Give Yaar or Datas: Was Decedant of Hispanic Orlgln? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1 ☐ Navar Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacadant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Waterman LIGODING 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Symama) Ernest 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Martin St. 5 NOW HILL Md. 2 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition Data 1 Buriai 2 Cramation 3 F 4 Donation 5 Other (Specify) 3 □Ramoval from Stata Coolspring Cemetary Girdletree ma. P. O. BOX331 21. Signatura of Funaral Service Licen Bennie Smith tuneral 23e. Pert1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart initure. List only one cause on each line. Immediata Cause (Final lyr Studder Cancer disaasa or condition rasulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disaasa or Injury that initiated events rasulting in daath) Last Dua to (or es e consequença of) Dua to (or as a consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas No

**Physician** /Medical Examiner

Examiner

**Physician** 

/Medical

Examiner

10a. Stata

Md

**Funeral** 

Director

28a-f show notified at

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Dependent of Health end Mentel Hygiene. Important: If item 27 is marked other than any injury or other tranmatic avant. The Man

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Peges 1 and 2 should be filed within 72 hours after

Maryland 21215-0020

Baltimore,

RATTER

Director

Funeral

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lician and buriel-transit physician the buriel Physician/Medical 80 for use signed by the a þ Completed certificete director, After this funeral within 24 hours after death. To the Funeral Director: A filled in by

Hospital or Attending Physician: The lew requires that the deeth certificate be executed

To the

P.O. Box 68760,

Records,

Division of Vital

26. Piece of Daath (Chack only one)

Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 28d. Describe how Injury occurred

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar 🕊 Certifying Physician: To tha best of my knowledge, deeth occurred et tha tima, deta and place, and dua to tha cause(s) and menner as stated. Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check of one) 29b. Signature and the of ce 29c. Licensa number

1450 497

29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of death (Item 23e) (Type, Print)

108 PINE BILIF RD SAHSbury MI 31. Data filed (Month, Day, Year)

State Registrar

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5 Pending invastigation

6 Could not be datarminad

25. Wes casa rafarred to medical axaminer?

1 ☐ Yas 2 No

27. Mennar of Death

Watural

2 Accidant

3 Suicida

4 Homicide

32. Registrar's Signatura Julia Davidson-Randalle

28a. Piaca of Injury - At homa, tarm, streat, factory, offica bullding, atc. (Spacify)

gregorians

JOHN FREDERICK BEUERLEIN

State of Maryland / Department of Health and Mental Hygiere

							Cei	rtifica	te of	Death			Reg. No.				
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		PHYSCIAN  5. Social Security No.		Sex		AL e (In yrs. last	highday	If Unde	r 1 Year	LA P		8. Date of B		IARI		(0)	
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er thi	n: T	27. Manner of Death		28a. Date (Mo		43	b. Time of		28c. Injur Wor			28d. Describe					ton as
or Attending Physician: after death. Director: After this certific in by the funeral director.	Certification:	1 Naturel 2 Accident	5 Pending investigation		199		330	<b>(</b> M	1 🗌	Yes 2 1	No	PASSEN	ion	CNI	can.	MPL	Scowin
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24b. Were autopsy findings available prior to completion of ceuse of deeth?

1 Nos 2 No

	PATRICK BETHARD	Н.		State of I	Maryland				lealth and i <i>Death</i>		giene	3 (	0933
	Physic /Medi		Decedent's Name (First, Mide     PATRICK	dle, Last) HUNT]	ER	F	BETHAL	RD		2. Date of Dea Month	-	1997	3. Time of Death
	Exami		4a. Fecility Neme (If not institution MD.RTE 354	on, give street and numbe	er)				4b. City, Town, or L PITTSVIL	LE	WICC	ty of Deeth	
	Funeral Director		5. Social Security Number 219-82-8272  Usual Residence of Decedent	6. Sex 1 M 2 □ F	Age (In yrs. la	ast birthday) Yrs.	if Under Months	1 Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day JAN . 13	, 1964	9. Birth	place (State or Foreign ntry) LAND
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Baltimore,	artment of actions of injury or of injury or of its	16	1 Dunial 2 Cremation 4 Donation 5 Other		te ce	metery, crer	netory or o	ther pla	1	Dete 9-27-97	20c. Location	BRIDGE	
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Box 68760,	cartifi ding ise a	Physician/Medical	that initiated events resulting in death) Lest	d	Due to (or e	es e conseq	uence of):					-	
P.O. E	at the death by the atter	Physici	Part II. Other eignificent conditi	one contributing to death	but not result	ting In the ur	nderlying c	euse giv	en in Part I.	23b. Did to			the cause of death?

The law requires th Division of Vital Records, Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificately filled in by the funeral director.

by Completed Be L O Certification:

25. Was case referred to medical exeminer?

29a Certifier

XXYes 2 No 27. Manner of Deeth 5 Pending investigation 1 Naturel

XIX Accident 3 Suicide 4 Homicide

6 Could not be determined

Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 9-26-97

2250p 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
STREET

28c. Injury at Work? 1 ☐ Yes 2 ◯No

26. Piace of Death (Check only one)

28d. Describe how Injury occurred DRIVER IN AUTOACCIDENT

Other: 4 Nursing Home 5 Residence 8 Other (Specify) SCENE

24a. Was en eutopsy performed?

1 No 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Rte. 354 Pittsville, MD

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

Medical 296 Bure and title of certific

O.C.M.E.

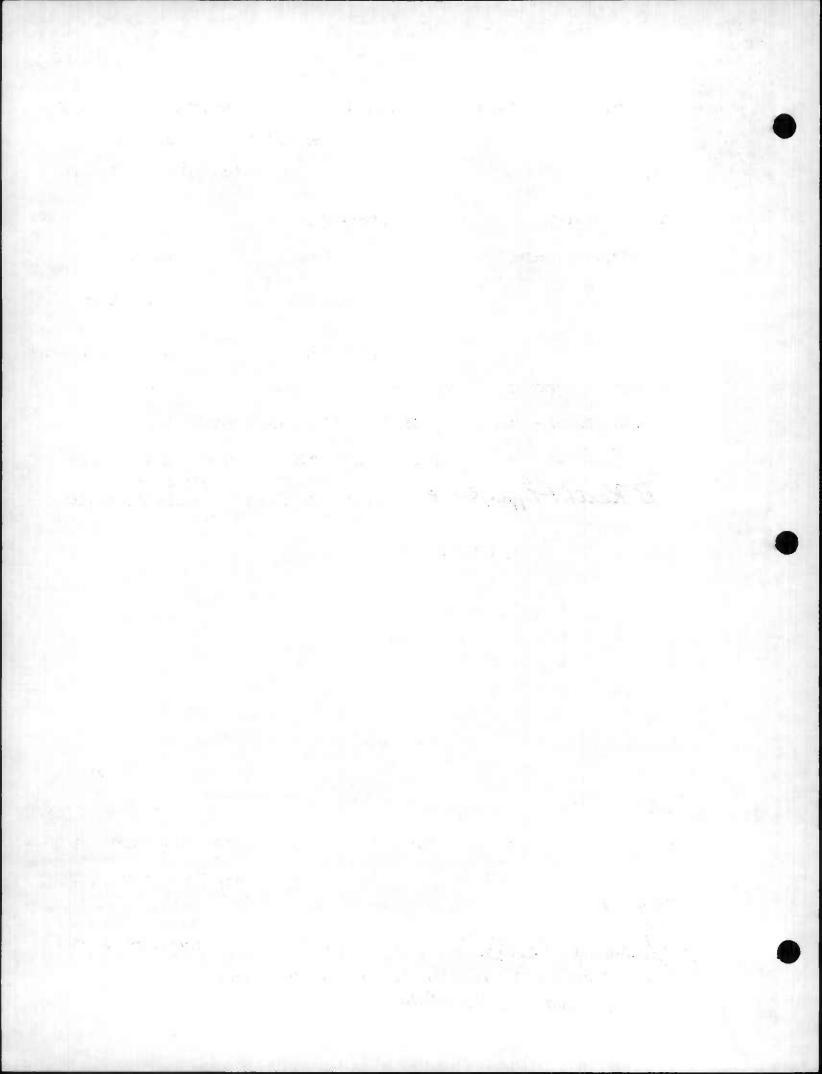
September 27, 1997

J. Laron Locke M.D., 111 Penn Street, Baltimore, Maryland 21201

120nder 5 State Registrar

31. Date filed (Month, Day, Year) SEP 2 9 1997 Jae Redistrar sisional Randall

To the Hospital within 24 hours a To the Funeral C completely filled



State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month EUGENE STHART BURKETT SEPTEMBER 28, 1997 /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (Stata or Foraign Country) **Funeral** 1⊠M 2□F Months Days 218-24-3991 Yes Director 68 January 23, 1929 Tennessee Usual Rasidance of Decedant 10a Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yas 2 No Director Maryland Wicomico Salisbury 10e. Street end Number 10f. Zip Coda 10a. Citizen of What Country? 508 Priscilla Street 21804 USA Funeral 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black. Whita, atc. 1 ☐ Yes 2 X No If Yas, Giva Year or Datea: 1 Navar Married 2 X Merried 1 Yas 2 No Specify by 3 Widowed 4 Divorced White Completed 16a. Dacedant's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Hygiana. Elemantary/Secondary (0-12) Collaga (1-4or 5+) 8 Cable Splicer C & P Telephone Co. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Surnama) s 1 and 2 should be fill Health and Mantal H tem 27 la marked oth marked Jesse Raymond Burkett Lois Hattie Tinley 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Department of Health ar Important: If Item 27 Ia eny injury or other trau Eunice Burkett/Wife 508 Priscilla St., Salisbury, MD 21804 20b. Placa of Disposition (Nama of camatery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 Donation Wicomico Memorial Park 10/1/97 5 Othar (Specify) Salisbury, MD 22. Nama end Addrass of Fecility MO1051 Holloway Funeral Home Part1. Enter the disease, or complications that could be death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Batween Onaat and Death **Physician** /Medical Immediata Causa (Final diseese or condition rasulting In daath) HEART FAILURE Examiner 2575700 ORGAN FAILURG Examiner be axecuted Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated avants rasulting in death) Last Dua to (or as a consequance of) and Physician/Medical tha Dua to (or as a consequence of): attending for use as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Type 2 No 3 Probably 4 Pl Unknown by should 24b. Wera eutopsy findings available prior to complation of causa of death? 24e. Was en eutopsy Completed paga 2 certificate 1 ☐ Yaa 2 2 No 1 Yas 2 No Hospital or Attending Physician: 24 hours after death. 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 27. Mannar of Death 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Panding Invastigation 1.2 Natural 1 ☐ Yas 2 ☐ No Director: / 2 Accidant 3 Suicida 6 Could not be datarminad 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stata) 4 Homicida To the Hospital within 24 hours a To the Funeral Completaly filled 29a. Certifian edical 🗠 Certifying Phyalcian: To tha best of my knowledga, daath occurred et tha tima, data and place, and dua to tha causa(s) and mannar as atatad. niner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. Licansa number 29d. Data signed (Month, Day, Year) ddress of person who causa of daath (Itam 23a) (Type, Print)

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32. Registrar's Signatura

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State Registrar SCHAE

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31. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0020

Box 68760

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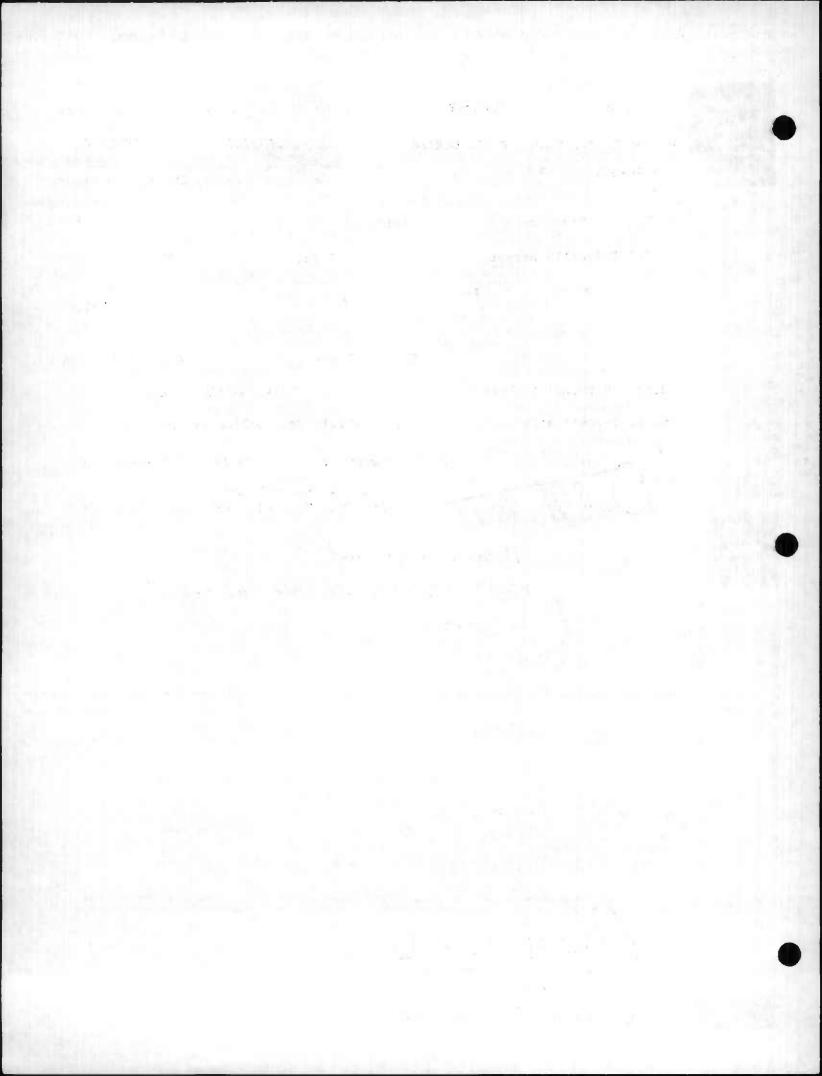
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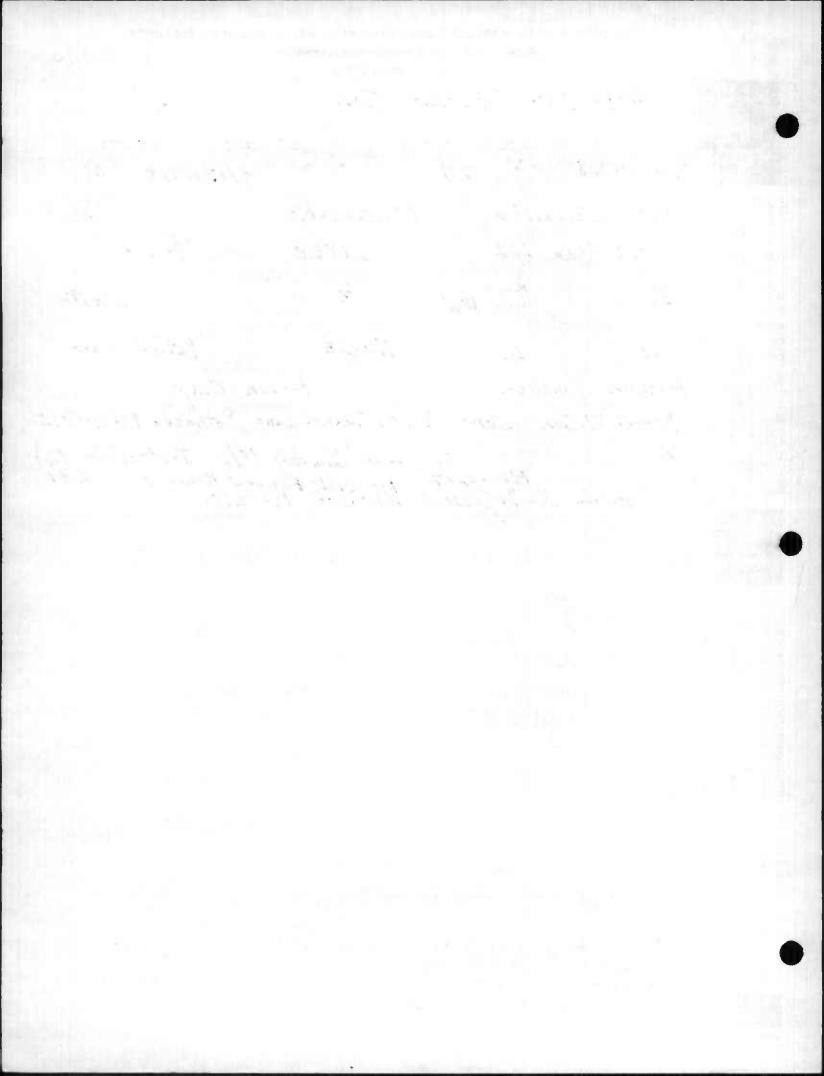
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State of Maryland / Department of Health and Mental Hygiene 7

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	- Lie			Certificate of	Death	Re	g. No.		
Physician /Medical	1	Decedent's Name (First, Middle, LATHERI	INE REBEC	CA COX		2. Date of Death Month SEPTEM	Day	Year	Time of Death
Examiner Funeral Director			IONAL MEDICAL CE		4b. City, Town, or Local SALISBI	ation of Death	4c. County	of Death	(State or Fore
a or 28a-f show be notified at	- 1		10c. City,	Nantic	oke				nside City Lin
23 62		P. O. Bay	< 102	10f. Zip Coda 2 / 8	140	10	2 -5	What Country?	
rat, or its		1. Marital Status  1 □ Naver Married 2 □ Married  3 Widowed 4 □ Divorced	12. Was Decedent Ever in U,S. Armed Forces?  12. Yes 2 \( \text{No}\) No It Yes, Give Year or Dates:	1□Van at Na	Hispanic Origin? (Speciban, Mexicen, Puerto Ri o Specify:	ify Yes or No- can, etc.)		a - American In k, White, etc.	ite
to Health and Mentel Hygiene. If item 27 is marked other than "natural", or ite or other traumatic event, the Medical Examina To Be Completed by Ful		15. Decedent's (Specify only highest g	Education trade completed)  College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	e during most of working ed)		6b. Kind of Bu	siness/Industr	
ind Mentel Hygiene. I merked other then umeric event, the M		7. Father's Name (First, Middle Las	nchex		18. Mother's Name (	First, Middle, M	elden Sumam	Θ)	
Health and em 27 is me other traum		19a. Informant's Name/Ralationship Robert W. Co	ox son		neo Linc	Bethe	2503,	Md 20	0815
Depertment of Hei Important: If Nem eny Injury or othe once.		Oa. Method of Disposition  Burial 2 Cremation 3  Donation 5 Other (Space)  Signature of Funeral Service Lice	oity) Oai	te of Disposition (Name of letery, cramatory or other place)	amatey ( resp of Facility  K Funes	Date 2	Oc. Location- Teste	City or Town, S	State
physician end street transit to buriel-transit edical Examiner		23a. Part1. Enter the disease, or conshock, or heart tailure. List only mmediata Cause (Final disease or condition resulting in daath)  Sequentially list conditions, and, leading to immediate cause. Enter Underlying Cause (Disease or Injury hat initiatad evants resulting in death) Last	a. Clubrata Due to (or a b. Due to (or a c.					Ons	roximate rval Betwee set and Deal
igned by the ettending post detached for use es	F	Part II. Other significant conditiona	contributing to death but not resulting	ng in the underlying causa g	ivan in Part I.	1 □ Ye	8 2 № No	atribute to the	/ 4□Unk
page 2 should			0			24a. Was an perform	autopsy ed?		le prior to tion of cause
s certificate he director, page	2	25. Was case reterred to medical examiner?	H. Ch.	To	26. Place of Death	1 ☐ Yes	/ \	1 🗆 Yes	s 2 No
within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.  Medical Certification: To		1 Yes 2 No  7. Manner of Death 1 Natural 5 Pending Investigation 3 Sulcide 6 Could not datamine	28a. Date of trijury (Month, Dey Year)	Bb. Time of Injury Wo	Yes 2□No	e 5 ☐ Resider  d. Describe how  t. Location (Str. City or Town,	w Injury occurr	ed	ute Number,
nours y filled		29a. Cartifiar 1 Certifytng P (Check only one) 2 Medical Exa	Physician: To the bast of my knowled miner: On the basis of examination and manner stated.	dge, death occurred at the t	time, date and place, an opinion, death occurred	d due to the call at tha tima, da	use(s) and ma ta and piace, a	nner as stated and due to tha	cause(s)
Fu Setel						700	d Date sloped	d didness Day	
within 24 hours To the Funeral completely filler Medical C	2	9b. Signature and title of certifier of certifier	Wennich, M.D.	29c. Licen	15384	29	9/30	(Month, Day,	Year)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of leath Month Physician LOUIS J. HICKMAN SEPTEMBEN 29 1997 0515 /Medical 4a. Fecllity Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** Months Days 1X) M 2 F Yrs. 216-18-8652 Director 80 12-29-1916 MARYLAND Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director WORCESTER MARYLAND BISHOPVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12321 DIXIE DRIVE (HOLIDAY HARBOR) 21813 U.S. Funeral 12. Wes Decadent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify p 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE DEVELOPER LAND DEVELOPMENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be CHARLIE W. HICKMAN MARIE (M.N.) HICKMAN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) VIVIAN HICKMAN 12321 DIXIE DRIVE, BISHOPVILLE, MD. 21813 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 D Burial 2 DiCramation 3 Removal from State Specify) ENTOMBMEN GRANITE MEMORIAL'S MAUS. BISHOPVILLE, MD. 4 Donatton 10-2-97 22. Name end Address of Fecility MELSON FUNERAL SERVICES THATCHER STREET, FRANKFORD, DELAWARE. 19945 Pale Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 3 Probably 4 ☐ Unknown 2016 1 Yas þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 20 No 25. Wes case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. cai 29a. Certifier (Check only one) Medi 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete cause of deeth (Item 23e) (Type, Print) SUITE A 206 SALISBURY, MD. 21811 560 RIVERSIDE DR Julia Davidson-Randall 31. Date filed (Month, Dey, Yeer) 32. Registrer's Signature State SEP 3 0 1997

Registrar

28a-f ahow

r is marked other than "natural", or items 23a or 28a-f ahov traumatic event, tra Medical Examiner must be notified at

d 2 should be filed within 72 th end Mental Hygiene. 7 Is marked other than "na

permit. Peges 1 end 2.
Department of Health er
important: If Item 27 Is-

be executed physician and s the burief-trens

> the signed by the

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Box 68760,

Records, P.O.

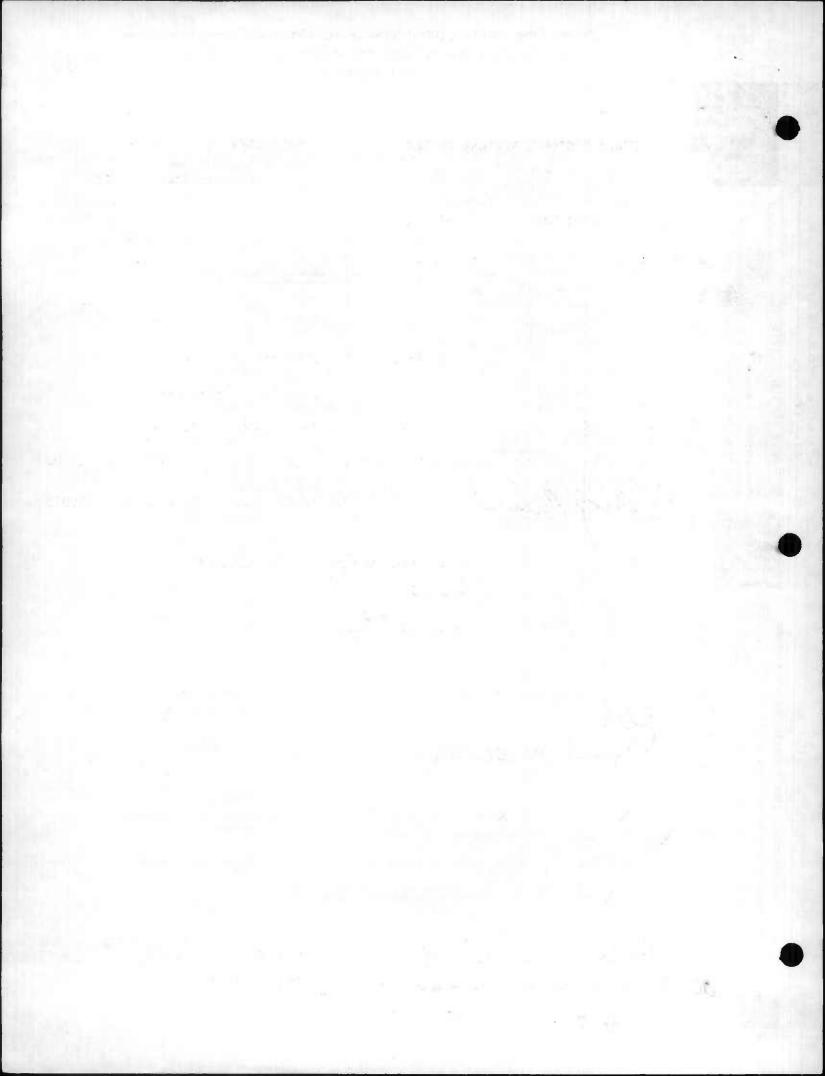
Division of Vital or Attending Physician:

21215-0020

Maryland

Baltimore,

0611



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** 101 ANE 12:27 Septer -bar 25 1997 /Medical 4b. City own, or Location of Death 4c County of Death 4a. Facility Nema (If not institution, give street and number) Examiner Adventist IA KUMA If Under 24 Hrs. Park Prince 5. Social Security lumber Georges Hosp!tal If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 6 Sev 7. Age (In yrs. last bilthday) **Funeral** 10 M 20 F Months Days Hours 92 Yrs 579 - 34 - 3323 Usuat Residance of Decedent Director November 28,1904 Marylance the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Tas 2 No Director Mary and Number Alver 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with Hygiene.
ther than "natural", or items 23a or Rd 1730 20678 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify by Specify. 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene important: If tiem 27 ia marked other tha any holury or other traumatic event, that once. Howenaker 12 1) onestic 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Brooks 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prince Reynolds Frederick Miece Lucille 20678 20b. Place of Disposition (Name of cemetery, crematory or other) 20s. Mathod of Disposition 20c. Location - City or Town, Stata Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removei from State Gardens 4 ☐ Donetion 5 ☐ Other (Specify) Forest 21. Signature of Bunerel Service License 22. Name and Address of Fecility Adams Tuneral Home 20608 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspirelory arrest, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours after death.

Fat hours after death.

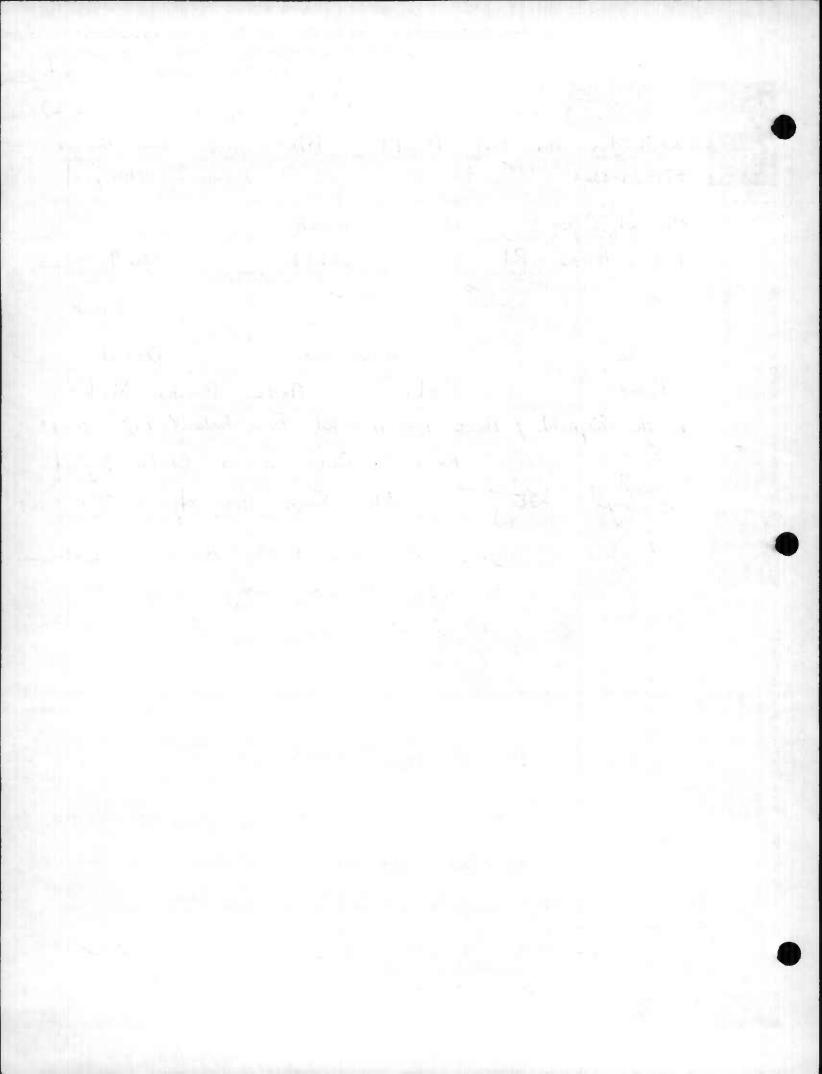
Fuerel Director: After this certificate has been signed by the attending physicien and either withe function of the present director, page 2 should be detached for use as the bunish-transit Sequentially list conditions, if any, leading to Immediata causa. Entar Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last P.O. Box 68760, Physician/Medical Due to (or as a consequence of) remi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ Completed 24b. Were autopsy findings evellable prior to complation of cause of death? 24a. Wes an autopsy performed? 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 12 Cartifying Physician: To the best of my knowledga, death occurred at the time, date end place, end due to the cause(s) and mannar as stated.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. Medical 29a. Certifier 29b. Signature end title of certifie 29c. License number 29d. Date signad (Month, Day, Year) 6 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) he wille 3060 32. Register's Signature

7 Julia Wheelen Randall 31. Data filed (Month, Day, Year) State

**DHMH 16 Rav 6/95** 

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** ELIZABETH HOWARD SEPT. 6:00 AM 30 1997 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Randallstown Baltimore AUGSBURG LUTHERAN HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Hours | Min. (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 M 2 F 154-01-5859 88 Yrs. Director Usuei Residence of Decedent 10e State 10h Counts 10c. City, Town or Location 10d. Inaide City Limits 28a-f show traumatic event, the Medical Examiner ( wat be notified at Maryland Baltimore 1 Yes 2 No None Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? U.S.A 21244 ashington Huenue Herns 23a Funeral Pages 1 and 2 should be filed within 72 hours aftar death 2. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married ò 1 ☐ Yes 2 No by Specify Black Specify: 3 Widowed 4 ☐ Divorcad 'natural', Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mantal Hygiene. Is marked other than Elamentary/Secondary (0-12) College (1-4or 5+) Jonestic Homemaker Baltimore, Maryland 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maldan Sumame) Smith George Rankin 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 3365 Forest Road Waldorf, Maryland 20601 Nephew other 20b. Place of Disposition (Neme of camatery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ABuriel 2 ☐ Cremetion 3 ☐ Removel from State 7 Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) West Creek Cometery October 4,1997 FUNERAL HOME P.A 21. Signature of Funerel Service Licensee 22. Nama a ADAMS 20605 AQUASCO RD AQUASCO MD 20608 23a. Pert1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart dilura. List only one cause on aect lina. Approximate onset end Deeth **Physician** /Medical Immediate Cause (Final · ACUTE COROWANY THROMBOSIS MINUTES disease or condition rasulting in deeth) **Examiner** ONOWARY ANTERY The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Lest Due to (or as e consequenca of) P.O. Box 68760. Physician/Medical Due to (or as e consequance of): director, page 2 should be datached for Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by 1 | Yee 2 | No 3 Probably 4 Unknown Hx at GASTROINTESTINAL BLEEDING 2° AV Malformation Records, Completed by 24b. Wara autopsy findings evailable prior to 24a. Was en autopsy performed? INSULIN REDUKING DIABETES MELLITUS completion of cause of death? this certificate has Stroke 1x at 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: Be 25. Was casa raferred to medical examiner? 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by tha funeral 27. Manner of Deeth 1 Matural 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending invastigation 2 No death. 2 Accident after death 8 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funaral C 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner stated. 29a. Cartifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of deeth (Itam 23a) (Type, Print) 30. Name and eddrass of person who completed

7000 PARK HUGHTS AVENUE

BARTIMOXE MD

State Registrar De borah I 31. Data filed (Month, Day, Year) OCT 0

Pierce

32. Registatis Signature.



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7 30939

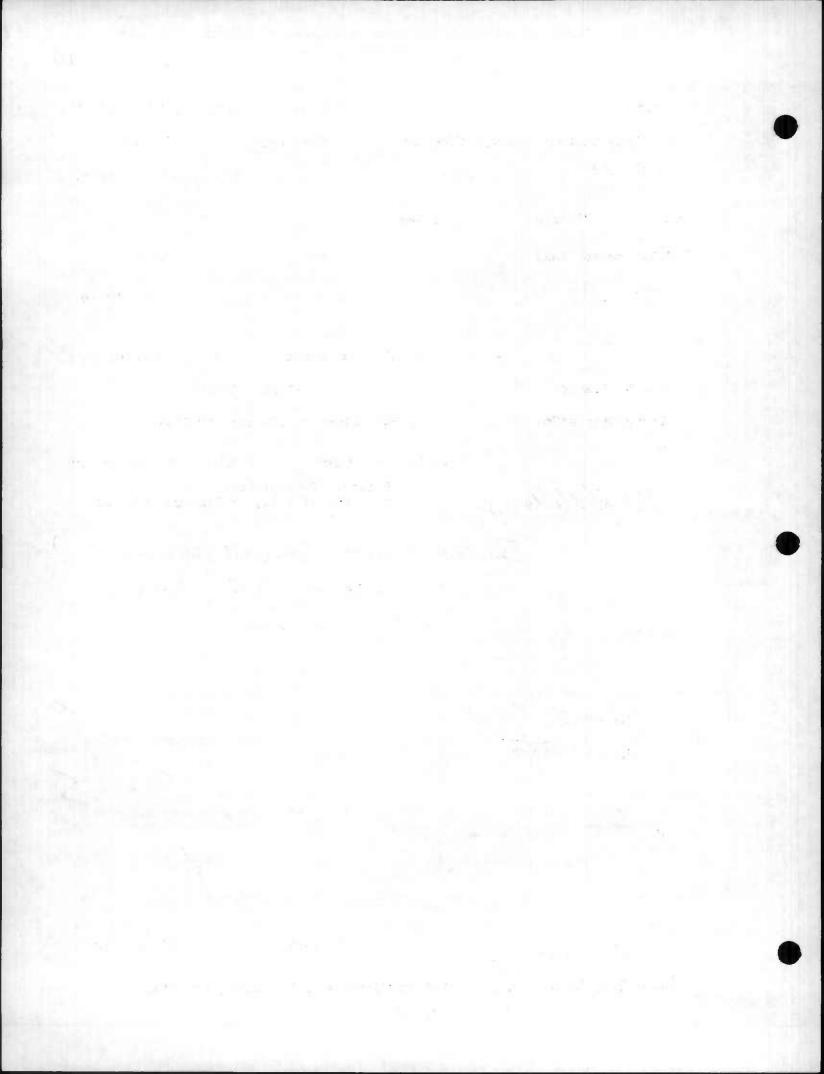
					Certificate of	f Death	Re	g. No.	
District Co.	,	1. Decedent's Nama (First, Middle,	_ast)				2. Dete of Deeth Month	Day Yes	3. Time of Death
Physic /Medi		ELEANOR	LOUISE		HOTTON			BEA 28, 199	
Exami		4e. Facility Name (If not institution, g	rive street end number)			4b. City, Town, or L	ocation of Deeth	4c. County of De	eeth
		PENINSULA REGI	ONAL MEDICA	L CENTE	ER	SALI	SBURY	WICC	OMICO
Funeral	Г		Sex 7. Age	e (In yrs. lest bii	rthday) If Under 1 Yee	r if Under 24 Hrs.	8. Dete of Birth (Month, Day, DEC . 10,		Birthplace (Stete or Foreign
Director		218-20-8997 Usuel Residence of Decedent	1□M 2 <b>X</b> )F	68	Yrs.		DEC.10,	1928 MA	RYLAND
yland		10a. Stete 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
Be-fsl	Director	MD WICO	MICO		SALISBUR				1 ☐ Yes 2 No
th with the		10e. Street end Number 608 NOTTINGH	AM Dr.		10f. Zip Code	1804	10	g. Citizen of Whet U.S.	
filed within 72 hours efter deeth with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Modical Examiner must be notified at	by Funeral	11. Maritel Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Wes Decedant I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Yaar or Dates:		13. Wes Decedent of If Yes, specify Cu		pecify Yes or No- Pican, etc.)	14. Rece - Al Black, W Specify:	marican Indian, hite, etc. WHITE
2 hou		15. Decedent's		16a	. Decedent's Usuei Occi	upetion	1	6b. Kind of Busine	
be filed within 72 ho ntal Hygiene. Id other then "netur event, the Medical	Completed	(Specify only highest (	rade completed)		(Give kind of work don life. DO NOT use retir	e during most of work	king	001 111110 01 0001110	our modelly
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d 2 should th end Men 7 is marke traumatic	-	19a. Informent's Neme/Reletionship	(Type, Print)	191	o. Malling Address (Street	et end Number or Rui	ral Route Number,	City or Town, Stete	e, Zip Code)
-		SUSAN G. DICKER	SON - DAUGH			NGHAM DR.		RY, MD 2	
Se of A		20e. Method of Disposition 1   ☐ Buriei 2 ☐ Cremetion 3	☐Removel from State	20b. Pleca o cemete	f Disposition (Neme of ry, cremetory or other p		Dete 2	0c. Location - City	or Town, Stete
rtant riant		4 Donetion 5 Other (Spec	-	PAR	SONS CEMETE	1	10-1-97	SALISBUR	Y, MD
pemit. Peg Depertment important: i any injury o		21. Signeture of Funerel Service Lic	Physon	CFSI	22. Name end Add	ress of Fecility UNERAL HON		E. MAIN	ST. ARYLAND 2180
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/Medical Examiner		Immediate Cause (Final disaasa or condition resulting in deeth)	θ	- (	ung Car	rcer			amo
	e.				consequence of):				~
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law requires that the deeth certificate be executed as been signed by the ettending physician and a 2 should be deteched for use as the burial-transit	edical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest	c		consequence of):				
eth certific ettending p	2		d						
the ed	Physician/	Pert II. Other significant conditions	contributing to death bu	ut not resulting i	n the undarlying cause (	given in Part I.	23b. Did tol	oacco uee contrib	ute to the cause of death?
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sw requires s been sign 2 should bo	Completed b	H	710				24a. Was er perform		b. Were eutopsy findings evellebla prior to completion of cause of death?
The law	E						1□ Ye	s 2000	1□Yes 2000
certificate	Be C	25. Wes case referred to medical				26 Place of Dee	th (Check only one		
ysician; The l s certificate he director, page	ToB	exeminer?	Hospitel: No Inpatie	nt 2□ER/O	utpatient 3 DOA	thor		nca 8 Other (S	inacihi)
ing Phy I. After this funeral o		27. Menner of Deeth	28e. Dete of Injur (Month, De)		Time of 28c. Inj		28d. Describe ho		респу)
To the Hospital or Attending Physician; within 24 hours effectedly.  To the Funerel Director: After this certifical completely filled in by the funeral director.	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be on Binn of the	ury - At home, fa c. (Specify)	arm, street, fectory, office		28f. Location (Str. City or Town,	eet end Number or Stele)	Rural Route Number,
Hospita 24 hours Funere	edical C	29e. Certifier 1 CertifyIng F	Physician: To the best of aminer: On the besis of end mannar sta	exemination an	e, deeth occurred et the ad/or Investigetion, in my	time, dete end plece, opinion, deeth occur	end due to the ce rred at the time, de	use(s) end menner te end pleca, end d	es steted. due to the cause(s)
ithin or the	Mec	29b. Signature and title of certifier	end mannar sta		29c. Lice	nsa numbar	29	d. Dete signed (Mo	onth, Dev. Year)
F 3 F 8		1	00-		12.1	50497			
2	3	30. Name end eddress of person wh		eeth (Item 23a)		7		9/30/97	
U		Chris Smyder D.	0. 108	PineB	int Rd.	Salis	bund	mo 2	1801
Sta Registr		SEP3 0 199	7 July of the	er's Signeture	Lall				

M. HOTTON 8995)

ELEANOR 215-20-



		1. Decedant's Nama (First, M	liddla, Las	st)					2. Data of D		25-0 I	3. Time of Death
Physic /Medi		Frances					Hic	hley	Septer	nber 28,	Yaar 1997	10:05 A
Exami		4a. Facility Name (If not instit	ution, give	e street and numb	per)			4b. City, Town, o				
		Salisbury Cen	-					Salisbur		Wicom		
Funerai Director		5. Social Sacurity Number 512-16-1522		ex	Aga (In yrs.	. last birthday) Yrs.	If Undar 1 Yaa Months Day		. (Month, D	irth Pay, Year) 2, 1909	9. Birthp Coun Miss	lace (Steta or Forei try) ouri
ž.,,		Usuai Rasidance of Dacadan 10a. Stata 10b. Co.			10c. Ci	ity, Town or Lo	cation				10	0d. Inside City Limi
-f sho	ō	Maryland W:	icomi	co		Delmar						1 ☐ Yes 2 ☐ N
28s	rec	10e. Streat and Numbar					10f. Zip Coda			10g. Citizen of	What Coun	itry?
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ital hygiene. di other than "natural", or itema 23a or 28a-f show event, the Medical Examiner must be notitied at	by Funeral Director	11. Marital Status  1 Naver Marriad 2		12. Was Deceda Armed Force 1  Yas 2 If Yas, Giva Year or Data	es? XI No		Was Dacedant of	Hispanic Origin? ( ban, Maxican, Pua	Specify Yes or N nto Rican, atc.)	o- 14. Rac	ce - Amaric ck, Whita, a y: Whi	atc.
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Department Important: I any Injury o once.		1111	1/	11 7			Holloway	Funeral				
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ysician Medicai	Н	Immediate Causa (Final disaasa or condition	Elst Only C			th. Do not ant	er tha moda of di	ying, such as cardio			Marin	Approximata Interval Between Onset and Death
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State of Maryland / Department of Health and Mental Hygiene Q 7

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Physici /Media		KAY	FRANCES	S Mc	CARTE	ER		SEPT	Pay 19	1997	1905
Examir		4a. Facility Name (If not institution, give				1 2 3	4b. City, Town, or L		,		205
		SINAL HOSPITA  5. Social Security Number 6. Si		e (In yrs. lest birt	thday) I	Under 1 Yaar		MORE	100		LORE ace (State or For
Funeral Director		220-28-0741  Usual Residence of Decedent				lonths Days	Hours Min.	8. Date of Bir Month, Da Aug 26	<sup>9.</sup> 1934	Mary.	land
ě u		10a. State 10b. County		10c. City, Town	n or Locati	ion				10	Od. Inside City Lir
a-f show	to	MD Dorches	ster		Cambr	ridge					1 🗆 Yes 📆
Herns 23a or 28a-f show ther must be notified at	al Director	10e. Street and Number 5152 Paw Pay	w Point Ro	1.		10f. Zip Code 21613			U.S.A		try?
Examiner my	by Funeral	11. Marital Status  1 Navar Married Married  3 Widowed 4 Divorced	12. Was Decedant Armed Forces? 1  Yas 2 If Yes, Give Year or Dates:			Decedent of I as, specify Cub Yes 25 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yas or No Pican, etc.)		e - America ck, Whita, e v: Whi	etc.
hath	Completed	15. Decedent's Ed (Specify only highest gre	ucation de completed)	16a.	Decedent (Give kind	's Usual Occup d of work done	pation during most of world)	king	16b. Kind of Bu	usiness/Ind	lustry
than to Me	du	Elementary/Secondary (0-12)	College (1-4or s	)+)		<i>NOT</i> use ratire			private	e nhv	sician
ant, I		17. Father's Name (First, Middle, Last)				20.2 6.0 11	18. Mother's Nam	e (First, Middle,			010101
tic av	To Be	Samue1	Joseph	Smit	h		He	1en	Emma	Co	llins
27 is ma r trauma		19a. Informant's Name/Relationship (7) Dr. James F. McCai					and Number or Ru Point Rd				
nt: If Iham ry or othe		20a. Method of Disposition  12 Buriai 2 Cramation 3 4 Donatlon 5 Other (Specify	Removal from State			on (Nema of ory or other pie ington	ca) Cemetery	Data 9-22-97	20c. Location - Hurlock		
mportant: any injury anse.		21. Signature of Funeral Service Licen		0	22. No	ame and Addre					
		1 Innett K	Thomas	>h'	700	Locus	t St., Ca	mbridge		13	
		23a. Part1. Enter the disaasa, or comp shock, or heart failure. List only	one cause on each li	Mha death. Dor ne.	not enter th	ne mode of dyl	ng, such as cardiac	or raspiratory a	rast,	į	Approximate Interval Betwee Onset and Deal
sician edical		Immediate Cause (Final disease or condition	MIDCH	10.11	11.	C4 0 67					11 1.
miner		resulting in death)	a. INIQUEA	Due to (or as a			ION				12 Mr
4	iner		PROBAR	-		ON AR	Y EMB	olus			2 hr
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shysic the b	edicai	that initiated events resulting In death) Last		Dua to (or as a c	consequen	ce of):		iky			
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ata has page 2	mo							10	res 2 No	1	Yes 2□ No
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Aftar t	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b. T	Time of njury	28c. Inju Wo	ryat rk?  Yes 2 □ No	28d. Describe I	now injury occur	red	
Director: After to d in by the funere	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, far c. (Specify)	rm, street,			28f. Location (: City or Tox	Street and Numb vn, Stata)	per or Rura	l Route Number,
To the Funeral Directory completaly filled in b	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	raician: To the best of iner: On the basis of and manner sta	examination and	, death oc d/or invest	curred at the ti igation, in my o	me, date and place opinion, death occu	and due to the red at the time,	cause(s) and ma date and place,	anner as stand due to	ated. the cause(s)
To the	Me	29b. Signature and title or certifiar	IN THE STATE OF TH			29c. Licens	se number		29d. Data signe	d (Month, £	Day, Year)
		1 Mass	- mD			AS 24	02321-H	G-9918	SEPTL	9 1	997
		30. Name and address of person who o	completed cause of d	eath (Item 23a) (	(Type, Prin	nt)					
		31. Date filed (Month, Day, Year)	2401	W. Se ar's Signature Dauwien	ived	ere /	Ive. Ba	ito, riy	41712		
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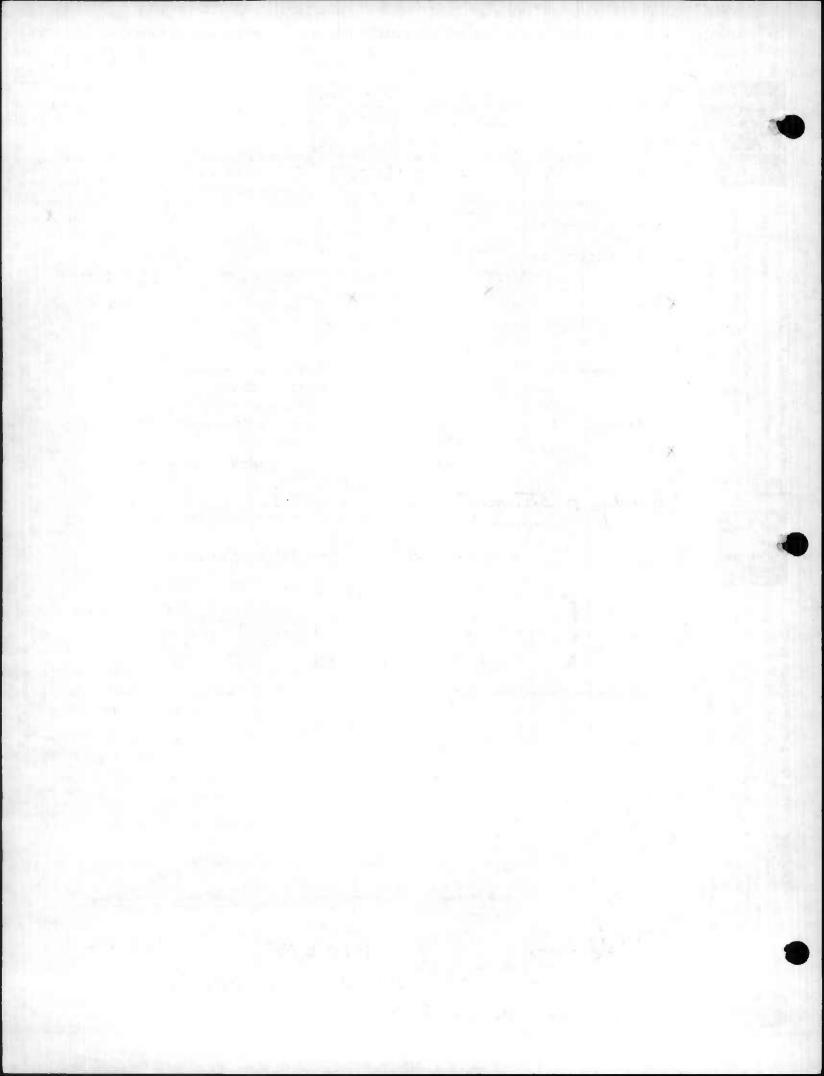
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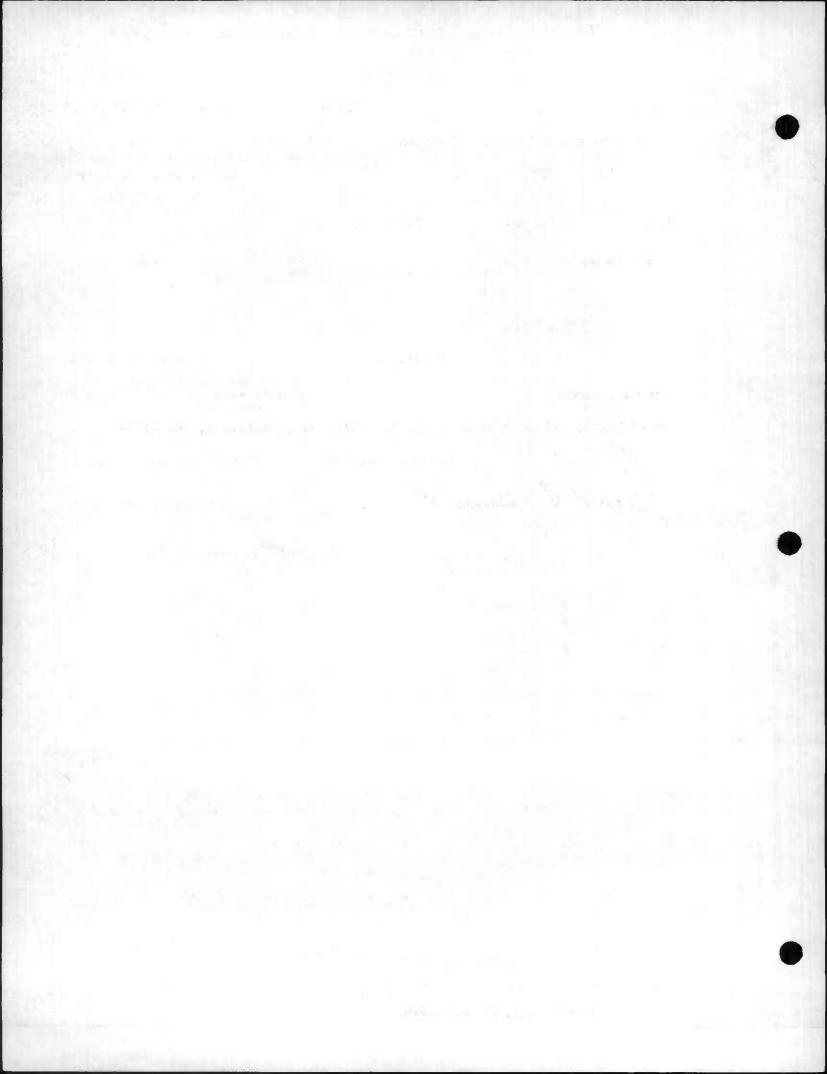
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 09 Day 25 PINDER JOHN 20.20 /Medical 4a. Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF MD. MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Jan. 29 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1MM 2□ F 219-07-6951 1920 Maryland Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Madical Examinat must be noticed at 1 ☐ Yes 2 No Director Maryland Wicomico Nanticoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Box 67 Nutter Road 21840 U.S.A Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1□ Yes 2 No þ Specify: 3 Widowed 4 ☐ Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) 1 2 College (1-4or 5+) Laborer None Department from 27 is more any injury or other injury or other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Austin Pinder SR. Myrtle Conway 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Pinder 111 (Son) Box 67 Nutter Road, Nanticoke, Md. 21840 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-4 Green Acres Salisbury, Md. 21. Signeture of Funeral Service Licenses 22. Neme and Address of Fecility Stewart Funeral Home 821 West Rd.Salisbury,Md.21801 40 B. Stewar 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fail, re. List only one cause on each line. Approximate rval Bet Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest and burial-1 Carebella Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Due to (or as e consequence of) attending p lock inafe the per Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b þ 24b. Were autopsy findings avelleble prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen page 2 2 No 1 ☐ Yes 2 No certificate I or Attanding Physician: aftar death. Director: After this certifica director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA funeral 27. Manner of Deeth 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Netural 2 Accident 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 Homicide To the Hospital within 24 hours a To the Funeral D 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) end menner es stated. Medical completaly 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner stated. 29b. Signature and title of furtifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) S. GREENE ST. BALTI. MD ODONKOR PATRICK.

State Registrar 31. Date filed (Month, Day, Year) SEP 291997 32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygierre

						Ce	ertificate of	Death	R	eg. No.		
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			Salisbury Cen	ter: Gene	sis Eld	erCare	S	alisbury	, MD	Wicomi	.co	
	Funeral Director		5. Sociel Security Number 214-10-7172	6. Sex 1 M 2□ F	7. Age (In yrs. 95	last birthday Yrs.	Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey Jun 30	Year) 1902		lece (Stete or Foreig try) yland
	pu .		Usual Residence of Decedent  10a. State  10b. Count	u.	100 Ci	ty, Town or I	onation				1	0d. Inside City Limits
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	Ne N	ecto	Md.	Wicomico	)	Sal	isbury					X
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0200-61212	72 hours effer death with the Meryland natural, or items 23a or 28a-f show dital Examiner must be neithed at	by Funeral Director	11. Maritel Stalus  1 □ Never Married 2 □ Mai  3 ☑ Widowed 4 □ Divorce	Armed Fr	2 No ive X No	,5. 13	. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☑ No		Rican, etc.)		ck, White,	
5	n 72 hours natural',	pe	15. Decede	nt's Education		16e. Dec	edent's Usual Occup	etion		16b. Kind of B		
7	C 1 0	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (		(Giv life.	e kind of work done DO NOT use retired	during most of world)	king			
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9	tei Hygid d other event, II	Be	17. Fether's Name (First, Middle	, Last)				18. Mother's Nam	e (First, Middle, I			
Maryland		ToE	Gus Q. Parson	ng				Ionnie	White			
2	W 3	-	19e. Informent's Neme/Reletion			19b. Ma	ling Address (Street			r, City or Town,	Stete, Zip	Code)
	CENE		Richard Turner	(Bro in	law)	118	Priscilla	St., Sal	ishury.	Md. 21	804	
υ			20e. Method of Disposition		20b. i	Place of Dist	position (Neme of emetory or other plea	1	Date	20c. Location -	City or To	wn, Stete
Ē			1 Buriel 2 Cremation 4 Donetion 5 Other (5		State		Cemetery		/29/97 9	Salishu	rv. M	d
	permit. Pag Department Important: I any Injury o		21. Signature of Funerei Service	Licensee	//		22. Name end Addre		, _ , , , ,	,		
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			220 Part Fater the disease	C	auno	Y Donate	Bounds Fu	neral Hom	e, Salis	sbury,	Md2	1804
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5	by the e	Physician/	Pert II. Other significant conditi	one contributing to d	leath but not res	ulting In the	underlying cause giv	en in Pert I.	23b. Did to	obacco use co	ntributa to	the cause of death
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ע	has b	ple									of	deeth?
		Son							1 □ Y	es 2 No	10	Yes 2 No
=	Physician: The this certificate are director, par	Be (	25. Wes case referred to medica exeminer?	nl				26. Place of Dee	th (Check only or	ne)		
or vital Records,	2 00 5	To	1 Yes 22 No	Hospital: 1 🗆	Inpatient 2	ER/Outpeti	ent 3 DOA Oth	er: Mursing H	ome 5 Reside	ence 6 Oth	er (Specify	y)
5	ttanding Phy deeth. stor: After this / the funeral		27. Manner of Death 1 ☑ Neturel 5 ☐ Pendi	28e. Dete	of Injury oth, Dey Year)	28b. Time Injury	of 28c. Injur Wor	y et k?	28d. Describe h	ow injury occur	red	
DIVISION	Attanding or deeth.  actor: After by the fune	atic	2□ Accident invest	igation	, , ,	,,		Yes 2□No				
<u>"</u>	or Attand efter deeth Director: / d in by the	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined   288. Piece	e of Injury - At h	ome, farm, s	treet, factory, office		28f. Location (St. City or Town		per or Rure	I Route Number,
5	od in De	Certification:		bano	iiig, etc. (opecii	"			ony or your	., 0.0.0)		
	To the Hospital or Atta within 24 hours effer de To the Funeral Directo completely filled in by the	edical (	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physicten: To the Examiner: On the b end man	best of my kno easis of exemine oner stated.	wiedge, dee tion end/or i	th occurred et the tir nvestigation, in my o	ne, date end plece plnion, deeth occur	end due to the c red et the time, d	euse(s) and molete end place,	enner es si end due to	eted. the ceuse(s)
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			30. Neme end eddress of person		so of dooth /li-	n 23a) /Turn		813		- / 00	, ,	
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		at o	Michael R. Atk 31. Dete filed (Month, Dey, Year	1115, M.D.	1 1 U4 Registrar's Signs	+ neal	ulway Dr.	, salisbi	rry, MD	21804		
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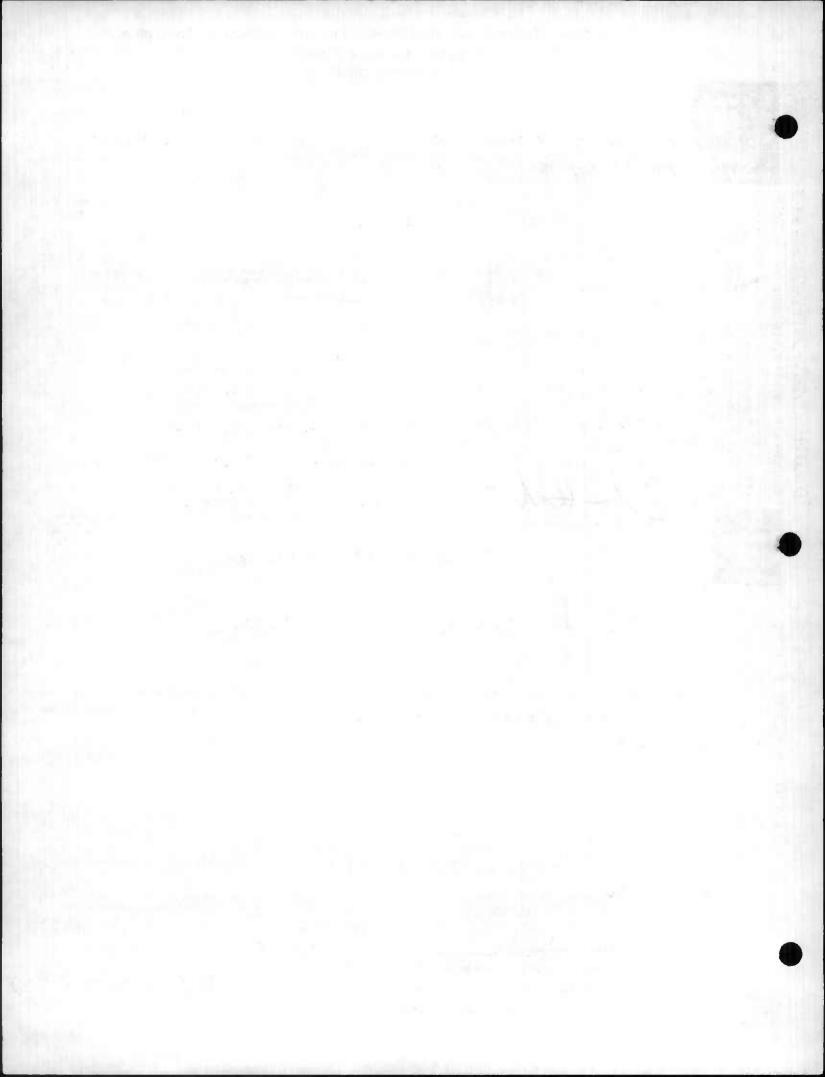
State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** David R. Taylor, Sr. September 34 1987
4b. City, Town, or Location of Deeth 4c. County of Deeth /Medical 4c. County of Deeth 4e. Fecility Neme (If not institution, give street end number) **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY Months Deys Hours Min. Mar 25, 1959 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F 4-52-44 Yrs. 38 Director NY Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ "natural", or items 23a 429 S. Division St. 21801 U.S. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Raca - American Indien. Bleck, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 Yes 2 No Specify: Specify: by Black 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Important or realth end Mental Hygione important: If item 27 is marked other than 'any injury or other traumatic event, the Man once. Elementary/Secondary (0-12) College (1-4or 5+) 10th n/a n/a 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Charles D. Taylor Ruth Alston 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Beatrice Lee Taylor /wife 901F Booth St., Salisbury, MD 21801 Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 【Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crematory 19/27/97 Salisbury, MD 21. Signature of Funerei Servica Licanse 22. Name end Address of Fecility Lewis N. Watson Funeral Home 1618 West Rd., SAlisbury, MD 21801 23a Further the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest mock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final MULTIPLE ORGAN FAILURE disease or condition resulting In deeth) Examiner Due to (or es e consequenca of): Physician/Medical Examiner SHOCK The lew requires that the death certificete be executed the burial-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of) pue Box 68760, VENTRAL HERNIA Due to (or es e consequence of) 8 P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by th. 1 Yee 2 No 3 Probably 4 Unknown RENAL FAILURE Records, Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, t 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) exeminer? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 XNo 27. Menner of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: Division 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and plece, end due to the cause(s) end menner stated. Medicai 29e. Certifier (Check only 5 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Menth, Dey, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SAUSBURY, MD 21001 45 E. CARPOU 31. Dete filed (Month, Day, Year) SEP 2 6 1997 82. Registrer's Signature Who d'Auxilian hardall State

Registrar

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State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Month MARGARET **EDNA** TAYLOR ptember 27,1997 2015 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY
If Undar 24 Hrs.
Hours Min. 8. ( WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year Months Days 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Yaer) **Funeral** 1□M 2⊠F Days 218-24-4401 Yrs. Director July 3,1914 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show event, the Medical Examiner numb be notified at 1 ☐ Yes 2 ☐ No Director Florida Bervard West Melbourne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 23a 2341 Vermont Street 32904 USA Funeral **Items** 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 72 hours efter 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No ft Yes, Give Year or Datas: 6 1 Yes 2 No Specify: by Specify: White 3 □ Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic other 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maldan Surnama) d 2 should be fi th end Mental I-7 Is marked of Thomas Byrd Gray Margaret M. Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Department of Health of Important: If Item 27 Is any injury or other tra William M. Taylor/son 2341 Vermont St., W.Melbourne, FL 32904 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State Wicomico Memorial Park 10/1/97 Salisbury, Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each liny. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examine Exam Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence ot) B physician s the bune Physician/Medical Due to (or as a consequence of): 28 ettending p for use as deteched Part il. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Ž should should 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of causa ot deeth? Completed pege 2 certificate Attending Physician: Be 25. Was case reterred to medicel examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No Invastigation 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) efter 4 - Homicide ö e Funeral Di Hospital 29a. Certifier 1 Certifying Phyalcfan: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end manner es steted. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and placa, and dua to the cause(s) end manner stated. rang. 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 2 KUR IHARA 145 E. CONNII ST. SALISBURY MO 21801 WALLACE M.D.

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State Registrar

Baltimore, Maryland 21215-0020

Box 68760

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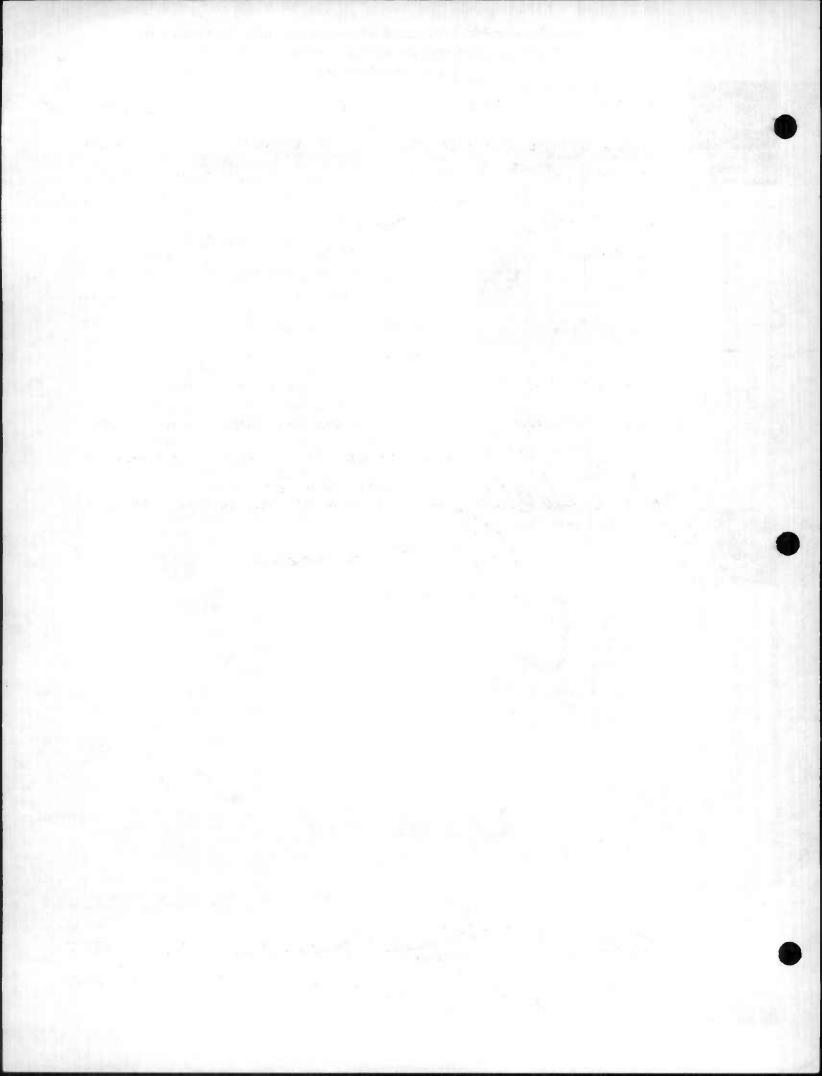
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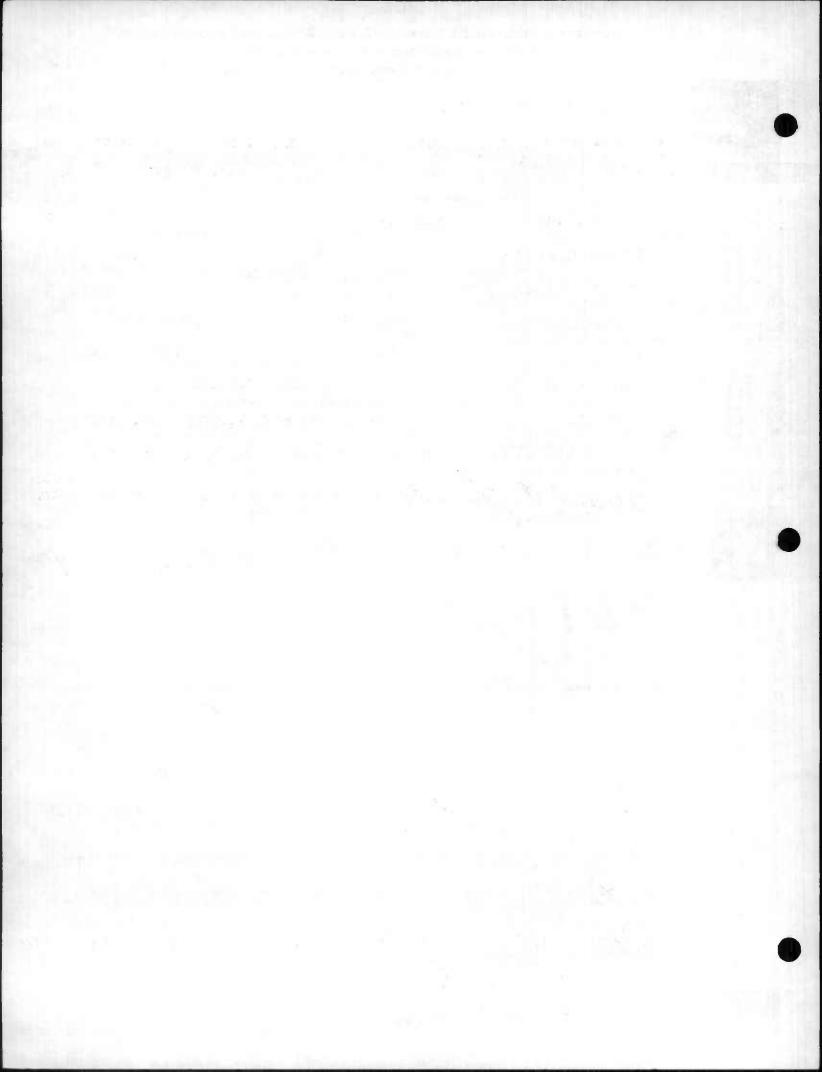
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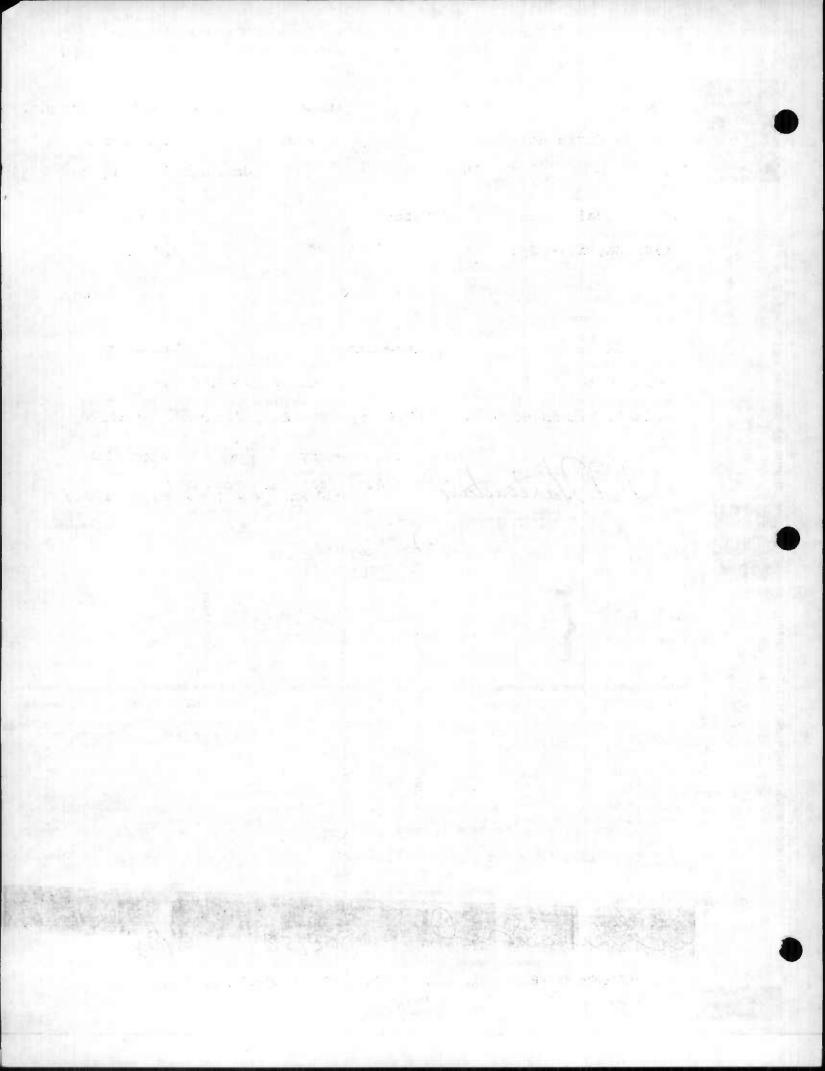
State of Maryland / Department of Health and Mental Hygiene

	-	- 8	1 Decedently Name	/Final Scientific Sec	-41			ertificate	OI D	Jaiii		Reg. No.		
	Physici	an	Decedent's Name		•						2. Data of De Month	Day	Year	3. Time of Death
	/Medi			MARGARET		WILKINS	S				SEPTEN		1997	03N
	Examir	ner	4a. Facility Name (If	not institution, giv	e street end nun	nber)			4b.	City, Town, or I	Location of Death	4c. County	of Death	
	H 0"			ULA REGI						SALIS			COMIC	0
	Funeral Director		5. Social Security No. 215-05-38		M M F	7. Age (In yrs. {	lest birthday 80 Yrs.	Months D		f Under 24 Hrs. Hours Min.	(Month, De	th y, Year) 25,1917	9. Birthp Coun	lace (Stete or Foreign try) MD •
	D		Usual Residence of									, , , , , ,		
	how		10a. Stata	10b. County		10c. Cit	y, Town or L	ocation.					1	0d. Inside City Limits
	h with the Marylar 23a or 28a-f show at be notified at	Director	MD.	WICOMIC	CO	PIT	TTSVIL	LE						1 ☐ Yes 2√ No
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		Funeral	11. Marital Status		12. Was Dece Armed For	dant Evar in U,	,S. 13.	Was Dacedent	f of Hisp	anic Origin? (S	pecify Yas or No o Rican, etc.)	- 14. Rac	e - Americ	
215-0020	a 5 5	by	1 Navar Marrie	ed 2 Married 4 Divorced	1 ☐ Yes If Yes, Give Year or Da	No No		1□ Yes 🐰			5 THOUSE, 510.7		y: WHI]	
2-0	"natural",	Completed	/Sneci	15. Decedent's Edify only highest gra	ducation		16a. Dece	edent's Usual O	occupatio	on ing most of wor	delan	16b. Kind of B	usiness/inc	dustry
72	thin an	ple	Elementary/Secon		College (1-	-4or 5+)	life.	e kind of work d DO NOT use r	retired)	ing most or wor	Killy			
- 64	filed with Hygiene. ther than	Son	9				SE	AMSTRES	SS			SHIRT	FACTO	ORY
3.5. Ind	be filed trail Hygi d other event, to	Be	17. Fathar's Name (						18		ne (First, Middle,	Maiden Sumen	ne)	
× a	should be nd Mental marked c	2	PETI	ER DAVIS	3					LYDA	CLAYVILI	LΕ		
Maryland	d 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, the M		19a, Informant's Na	me/Reletionship (	Type, Print)		19b. Mail	ling Address (Si	treet end	Number or Ru	iral Route Numb	er, City or Town,	Steta, Zip	Code)
	1 and Health em 27		LINDA I	BRATTEN						LE ROAD	, PITTSV	/ILLE,MD	. 218	350
Baltimore,	ges 1 and t of Health If Rem 27 or other to		20a. Method of Diep		Dom suel from 6		Place of Disponentary, cre	osition (Neme o	of r place)		Data	20c. Location -	City or To	wn, Stata
imor in	Pages nent of int: If its iry or o			☐ Cremation 3 ☐ 5 ☐ Other (Specifi			OWELLV	ILLE CE	METE	ERY	10/1/97	POWELLV	ILLE,	MD.
S E	permit. Pag Department Important: I any injury o		21. Signature of Fun	neral Service Licen	1900	//	0 2	22. Nama and A	Address	of Facility				21804
m	Depariment in any ir		D 4	. 1	1	K	-X #	OHNIDS E	TIME	AT HOM	E 705 E	MATN C	T CA	ALISBURY,M
	Physician /Medical Examiner		Immediate Cause (F disease or condition resulting In death)	Final 1	. chr	nnic		1 1	1	4	/			
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ó	an and inal-transit	Examiner	Sequentially list con if any, leeding to im- cause. Enter Under	aditions, mediate tying	b		or as a conse		oct	112	Pulis	reasel		20 yrs.
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list con if any, leading to imicause. Enter Under Cause (Disease or I that Initiated events resulting in death) L	nditions, mediate tlying njury ast	b	Due to (o		equence of):	oct	1/2	Polis	ronary rease		20 yrs.
ox 68760,	as as	n/Medical Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or I that initiated events resulting in death) L	iditions, mediate lying niury	b	Due to (o	or as a conse	equence of):	oct		Polis	monary ease		20 yrs.
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DHMH 16 Rev 6/95



	2.					n waryia		tificate of	Death		Reg. No.	30	941
п	Physic	ian	1. Decedent's Nan	na (First, Middle	, Last)					2. Data of De Month	ath Day	Year	3. Time of Death
	/Medi		ELSI	E		MAY		WIL	SON	Octobe			2:17 p.m.
Ы	Exami		4a. Facility Name	If not institution,	giva straat and nu	m <i>ber</i> )			4b. City, Town, or L	ocation of Death	4c. Count	y of Death	
			Stell	a Mari	s Hospid	ce			Towson		Bal	timo	re
1	Funeral	П	5. Social Security I		6. Sax		. last birthday)	If Under 1 Year	If Undar 24 Hrs.	6. Data of Bir	h		
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h	o		Usual Residence	of Decedant									
	ylan		10a. State	10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	Ma F	io	MD	Balt	imore	F	Parkto	n					1 ☐ Yas 2X No
	7 28 P	- F	10e. Street and Nu	mber				10f. Zip Code			10g. Citizen of	Whet Coun	itry?
	3a o	2	1308	Rayvil	le Rd.			211	20		U.S.	Α.	
	death	Funeral Director	11. Marital Status		12. Was Deci	adent Evar in U prces? 2 No	U,S. 13. V	Vas Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	14. Ra	ca - Amaric	
21215-0020	n 72 hours efter death with the Maryland "natural", or fisms 23a or 28a-f show edital Examiner must be notified at	þ	1 ☐ Nevar Man 3 ☐ Widowad	ried 2 X Marrid 4 □ Divorced	ed 1 ☐ Yes If Yas, Giv	/8		☐ Yes 2X No	Specify:	rican, atc./	Specif	ck, Whita, by: Wh	ite
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21		P.		11			Home	emaker			Own	Home	
pu	be filed tal Hygie of other event, tr	Be (	17. Fathar's Nama	(First, Middla, L	ast)				16. Mother's Nam	a (First, Middle,	Maiden Sumar	ne)	
Maryland		To	LeRoy	Hare					Cather:	ine Ho	ffman		
an	d 2 should Ith and Men 7 is marked traumatic		19a. Informant's N	ame/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Street	and Number or Rui	al Route Number	r, City or Town	, State, Zip	Code)
	5565		Donald	L. Wils	son/Hush	and	1308	Rayvi	lle Rd.,	Parkt	on, MI	211	120
9			20a. Method of Dis	position		20b.	Placa of Dispos	sition (Name of netory or other pla		Date	20c. Location	- City or To	wn, Stata
Baltimore,	Pages nent of I nnt: If Ite			☐ Cremation 5 ☐ Other 戶	3 Removal from			ve Cemet	O.C.	t. 9,	Parkto	n N	(D
三	permit. Pag Department Important: I eny injury o		21. Signature of F	-	Jackson 1	122	_	Neme and Addre		1997	Palke	)11 , P.	עוו
Ba	permit. Pages Department of Important: If II any injury or once.		\( \sqrt{\partial} \).	J.X	Parton	stern	J	.J. Har	tensteir d St., N	Morti	ary,I	nc. PA 1	.7349
			23a. Part . Enter t shody, or her	he disease, or o	complications that confused on e	aused the dea	th. Do not ente	er the mode of dylr	ng, such as cardiec	or respiratory as	rest,		Approximate Interval Between
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68760,	ysici ysici	edicai	triat initiated event	5	C	Dua to (	or as a consequ	ience of):					
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Box	death certif e attanding ed for use e	Physician/M			d								
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<b>\rightarrow</b>	Physician: The i this certificata he ral director, page	Be	25. Was casa refer axaminar?		Hospital:			011	26. Place of Deet	h (Check only o	ne)		
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Sic	Attending or death. ector: Aftai by the fune	cat	2 ☐ Accident 3 ☐ Suicide	Investiga 6 Could no	Color Color			M 1 🗆	Yes 2 □ No				
≥	or Attendated of Director:	듣	4 Homicide	determin	ed Zea. Placa	of Injury - At h		et, factory, office		26f. Location (5 City or Tox		ber or Rurai	l Route Number,
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	5 1 × 1 × 0		29b. Signature and	the of partifier	a al	2		29c. Licans	e number		29d. Date signe	d (Month, L	Jay, Year)
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			30. Name and addr	ess of person w	ho completed cause	e of death (Iter	m 23a) (Type, F	Print)			100		
				NELOPE E				VALLEY RI	D. TIMON	IUM, MD	21093		
	Sta		31. Date filed (Mon			trar's Sign	atura						
	Registr	ar		OCT 15	তেওঁ/	Day	idson Par	dell					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death Day reaser 1-30 om Septe Clarence 97 her 2) 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL CENTER 5. Social Security Number If Under 1 Yeer Months Days If Under 24 Hrs. Houra Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yes Birthplace (State or Foreign Country) 1₩ 2□ F 89 Yrs. 578-10-3035 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Prince George's Che1tenham Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20623 10508 Frank Tippett Road 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Marital Status Bleck, White, etc. 1 X Yes 2 □ No if Yes, Give Year or Dates: 1 Never Merried 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 6 Carpet Enstaller Construction' 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary E. Yeager John Yeager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Linda C. Yeager (Daughter) 10508 Frank Tippett Rd Cheltenham, MD 20623 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removel from Stete Metropolitan Crematory 10-2-97 Alexandria, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of 90 neral Service Licenses 22. Name end Address of Fecility J.H. Eberwein Mortuary M00173 bem 4433 White Pls La White Pls., MD 20695 23a. Ph.1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Due to (or es a consequence of): Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting In death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yea 2 | No 3 | Probably 4 Uhknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ NG 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 / Impatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending Investigation 1 Yes MA 2 ☐ Accident

Physician /Medical Examiner The lew requires that the death certificate be executed

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

py

Completed

Be 2

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, in a Medical Examine must be notified.

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Hospital

To the Vithin 2

physician end the burial-transit 88 980 page 2 s

24 hours a

Physician/Medical Examiner Certification:

þ Completed Be 2

Medical

signed by the a peed certificate has After this after death.

29a. Certifier (Check only one) 29b. Signature and title of could

3 ☐ Suicide

4 Homicide

6 Could not be determined

MA

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

2 No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) 44 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29d. Dete signed (Month, Day, Year)

1		
Name and address of person	n who completed cause of death (Item 23s) (Type F	200

700

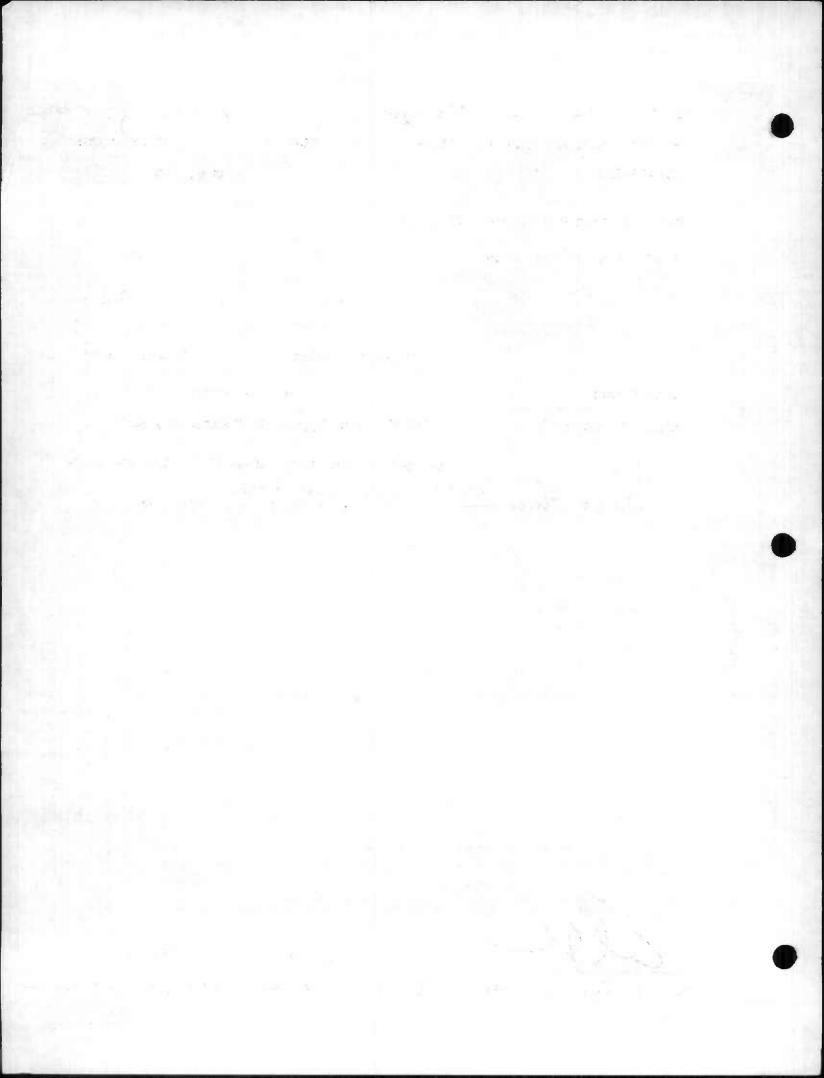
Dh

012 32. Registrar's Signature Alia Davidson Randall

31. Dete filed (Month, Dey, Yeer) State Registrar

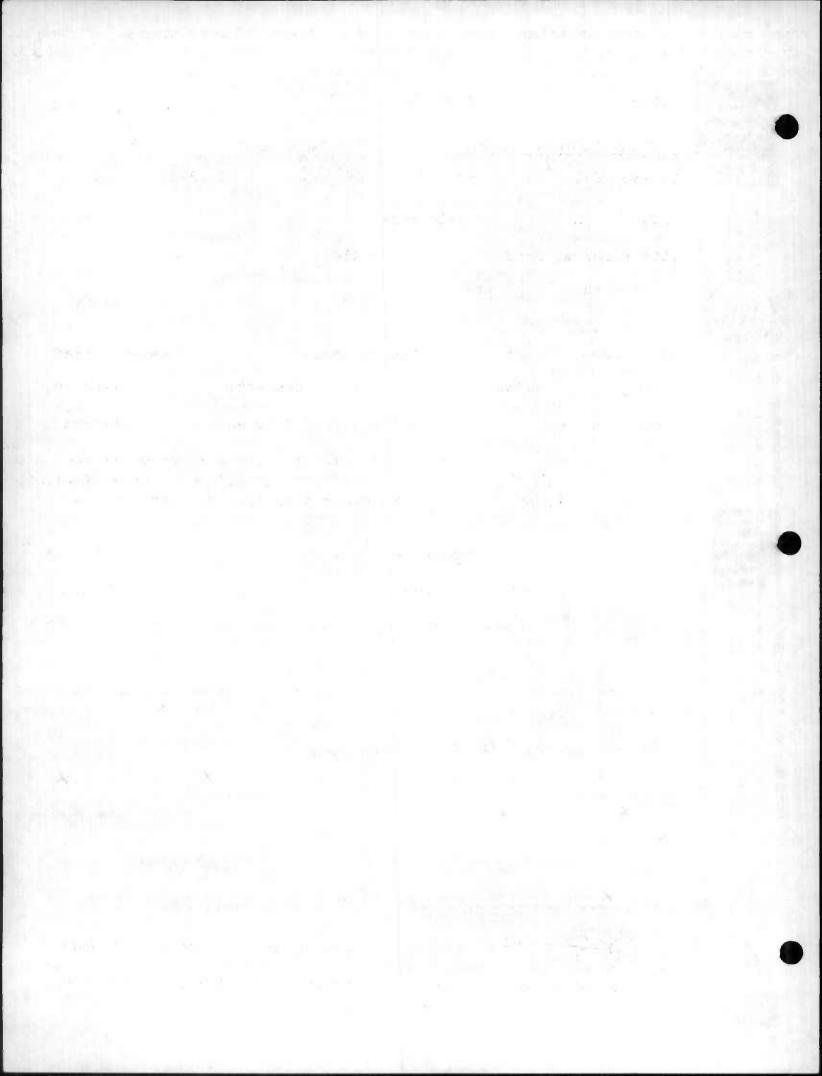
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DHMH 16 Rev 6/95



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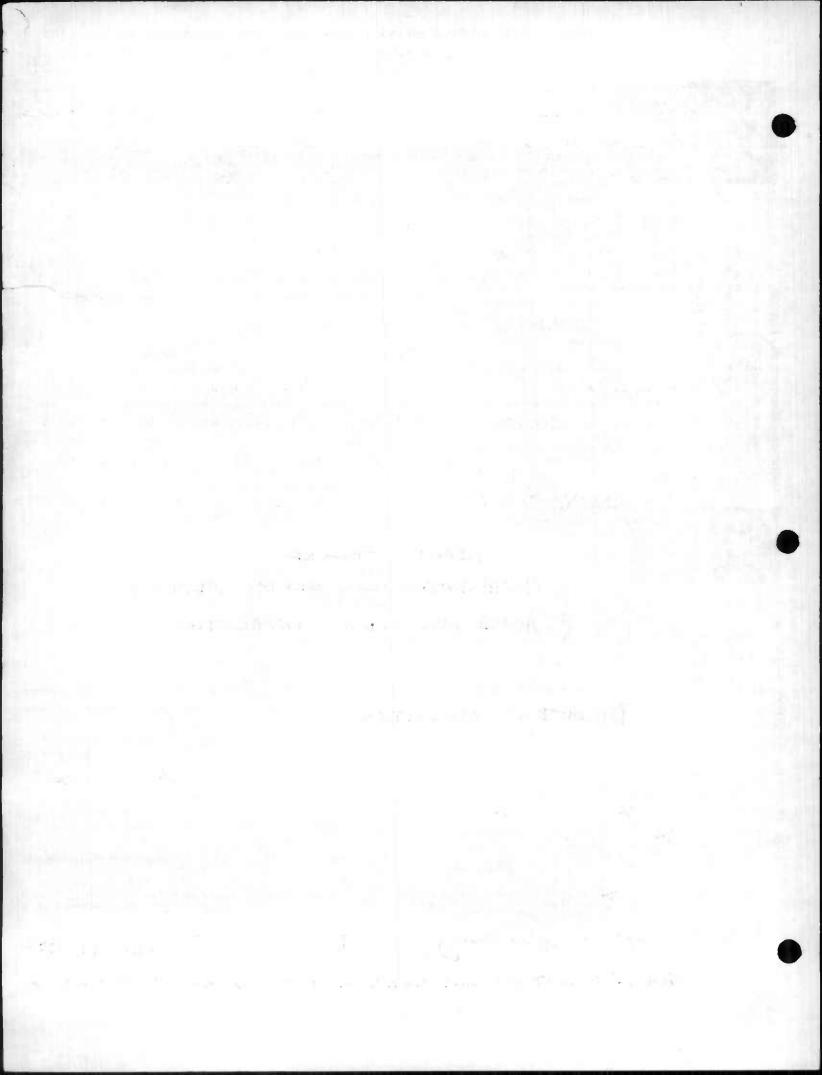
				Certificate o	f Death	Re	g. No.		
Physician /Medical	1. Decedent's Neme (First, Middle, La William	ost) A	LFORD			2. Dete of Deetl Month OCTOBER	Dey	Yeer 997	3. Time of Deeth
Examiner	4e. Fecility Neme (If not institution, gi		T	176 6	4b. City, Town, or Lo		4c. Count	y of Deeth	
uneral rector	5. Social Security Number 6.	Sex /. Age	(Th yrs. last birth	Months Dey	ar If Under 24 Hrs.	8. Dete of Birth (Month, Dey, 04-12			elece (State or Foreig etry)
fled at for	10a. Stele 10b. County  MD . NA		10c. City, Town Baltim					1	0d. Inside City Limits
trams 23s or 28s-f show tings must be notified at Funeral Director	10e. Street and Number 1505 Kingsway	Road		10f. Zip Code 21218		10	Og. Citizen of	Whet Cour	ntry?
Evening must	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:		13. Wes Decedent of the Yes, specify Control of the Yes 2 K N	Hispenic Origin? (Spuben, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,	
other that indicates our transfer our transf	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12) 11th Grade  17. Fether's Neme (First, Middle, Las	completed)  College (1-4or 5+  NA	,	Decedent's Usuel Occ Give kind of work dor life. DO NOT use reti	upation le during most of work red)  man  18. Mother's Name			ship	Trade
marked of	George	Alford			Henre		rologir Carrio		christ
art.	19e. Informent's Neme/Reletionship Nora Alfor				et end Number or Run way Road				
- 2	20e. Method of Disposition  1 Burial 2 Cremetion 3 [ 4 Donetion 5 Other (Special	Removel from State (y)	20b. Plece of l	Disposition (Neme of , cremetory or other p	lece)	Dete 2	20c. Location	- City or To	
Important: I any injury o once.	21. Signature of Funeral Service Lice	nsee		22. Neme end Add	rch FH 1			_	nd 21202
ettending physician end  Ifor use es the bunel-transit  clan/Medical Examiner	disease or condition resulting in deeth)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	b. HEPATIC	ue to (or es a co	onsequence of):  SCESS.  onsequence of):  CKY TI	tRombosis			1	WEEK.
be detached for use	Pert II. Other significant conditions of	-	-	, ,		23b. Did to	10		the cause of death
2 should be d	LIVER CIRRO	Hsis S/P	liver	TRANS	OLANT.	24e. Wes er perform		ev co	ere autopsy findings alleble prior to mpletion of cause deeth?
or, page	25. Was cese reterred to medical						s 2 No	10	Yes 25 No
To B	examiner? 1 Yes 2 No  27. Menner of Deeth 1 DNaturei 5 Pending 2 Accident Investigetio	28e. Dete of Injury (Month, Dey )	2 ER/Outs	me of ury 28c. in		me 5 Reside 28d. Describe ho	nce 6 🗆 Otl		у)
completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	building, etc.	(Specify)	n, street, factory, offic		28f. Location (Str City or Town	, Stete)		
the Fune pletely fil ledical	29a. Certifier ↑ Certifying Pr (Check only one) 2 Medical Exam	ysician: To the best of e niner: On the basis of e end menner state	xeminetion end	deeth occurred at the for investigetion, in my	time, date end piece, r opinion, deeth occurr	end due to the ce ed et the time, da	use(s) end m ite and plece,	enner es si and due to	tated. the ceuse(s)
Com	29b. Signeture end title of certifier	MD.			rise number		ed. Dete signe		1197
State	30. Name end eddre all person who  Dr. Kamal S  31. Dete tiled (Month, Dey, Year)	completed cause of dee awan, MD, 32, Pregistrer	ЈНН	600 No	rth Wolf	e Stree	et Bal	timo	21205 ore,Md.



State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First,	Middle, La	ist)		001	rtificate of	Death	2. Dete of Dear			3. Time of Death
Physici		Mayi	110	10			AULA	2611	Month	Day	Year	7:42
/Medi Examir		4a. Fecility Name (If not ins	itution, giv	ve street and number	or)		TULIT	4b. City, Town, or	Location of Death	4c. County	997 of Death	1. Tap
Exami		Washington .	Adven	tist Host	nital			Takoma 1	Park		ntgome	rv
Funeral		5. Social Security Number	6. 5	Sex 7.		. lest birthday)	If Under 1 Year	If Under 24 Hrs.				ce (Stete or Foreign
Director		217-06-0865 Usual Residence of Decede		1 <b>X</b> M 2□ F	69	Yrs.	Months Deys	Hours Min.	8. Date of Birth (Month, Dey July 5,	1928	Pakis	stan
the Maryland 28a-f show notified at	×	10e. State 10b. C	ounty		10c. Ci	ity, Town or Lo	cation				10	d. Inside City Limits
Pe M 28a-f notifie	ecti		ward		La	aurel						1 ☐ Yes 🎾 No
Z3e or	Funeral Director	10e. Street end Number 8288 Hammon	d Bra	nch Way			10f. Zip Code 2072	23	1	0g. Citizen of V USA	Whet Countr	y?
ed r	ne	11. Maritai Status		12. Was Deceder Armed Force	nt Ever in U	J,S. 13.	Was Decedent of I	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No-		e - America	
ar, or h	by	1 ☐ Never Married 2X 3 ☐ Widowed 4 ☐ Div		1 ☐ Yes 2 ₽ If Yes, Give Yeer or Dates	§ No		1□ Yes 2፟No		7 110411, 010.7		Ind	-
72 ho hastur fical	Completed	15. Dec	edent's Ed	ducation ade completed)		16a. Deced	lent's Usuai Occup	pation	tion	16b. Kind of Bu	usiness/Indu	stry
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THE !	Co	12		5+		Polic	e Office	er		Gover	nment	
Mil	Be	17. Father's Name (First, Mi		)				-20	ne (First, Middle, I	Aeiden Sumem	10)	
344	2	Banta S. Au							Kahlon_			
CA III TO TO		19a. informant's Name/Rela	itionship (	Type, Print)				t end Number or Ru				
f and feelth m 27		Charanjit S	. Au1	.akh/Son	Oat 1			Branch	1			
or of or of		20a. Method of Disposition 1 ☐ Buriai 2 X Creme	tion 3 🗆	Removel from Stat	e 20b. I	Place of Dispo cem <i>etery</i> , crem	sition (Name of netory or other ple	ece)	Date	20c. Location -	City or Tow	n, State
Pa ment: jury		4 □ Donetion 5 □ Oth	er (Specif	W _				gton Cr.	10/11	Laurel	, Mar	yland
apartition of the property of		21. Signature of Funeral Se	vice Licer	1888		22	Name end Addre	ess of Facility	mo Tno			
80558		tom	100/	3400 L	10					aurel	Mary	land 20707
		23a. Part1. Enter the disees shock, or heart failure.	e, or com	plications thet caus	ed the deat	th. Do not ent	er the mode of dyl	ing, such as cardied	or respiretory err	est,		Approximete
Physician		shoot, or year, railure.	LIST OFFIY	one cause on each	iine.							nterval Between Onset and Death
/Medicai		immediate Cause (Final disease or condition			HEA	0-	FAIL	10€			‡ 	
Examiner		resulting In deeth)		8.	Due to (	or as e conseq	uence of):					
p #	ner			ACUTE	VEN	TRICI	ILAR	SEPTA	L DE	FF.C	7	
tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions,		b	Due to (d	or es e conseq	uenca of):	SEPTA				
e exe		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury						INF				
he bi	edical	that initiated events resulting in deeth) Last	5	c. / LCO (L	Due to (c	or es e consequ	uence of):	. (///	11/2 111			
5 0 6	-	rooding in dooring cast										
death cer e attendin ed for use	and			d								
0 0	sici	Part II. Other eignificant co	ditions of	ontributing to death	but not res	ulting in the ur	nderlying cause giv	ven in Part I.	23b. Did to	bacco use cor	ntribute to t	he cause of death?
one the death celled by the attendir detached for use	Physician/								1 🗆 Y	0 202No	3 Proba	bly 4 Unknown
signed del	by I	1)18	BEI	ES	MIE	LLIT	US					
v requires that the been signed by th should be detache									24a. Wes a		24b. Were	e eutopsy findings eble prior to
Z S S	Completed								ponon	1001	com	pletion of cause ath?
The law ate has b page 2 s	E O								1□ Ye	s 25 No	10	Yes 25(No
	BeC	25. Was case referred to me	dical					26 Piece of Dee	th (Check only on			163 254110
	ToB	examiner?		Hospitei:	tient 2	ER/Outpetien	3□ DOA Oth	hor:	ome 5 Reside		ar (Specifi)	
ding Phys h. After this funeral d		27. Menner of Deeth		28a. Date of In (Month, D		28b. Time of	28c. Injur		28d. Describe ho			
6 4 5	atio		ending restigation		ey rear)	Injury		Yes 2 □ No				
ath.	Certification:	3 ☐ Suicide 6 ☐ C	ouid not be	286. Placa of I	njury - At h	ome, farm, stre	et, factory, office		28f. Location (St.	reet end Numbe	er or Rural I	Route Number,
Attendi or death. ector: A by the fi	7	4 - Homicide		building, e	tc. (Specif	γ)			City or Town	, Stete)		
or Attendifier deat Sirector: in by the	ē		ifving Phy	ysician: To the bes	of examine	wledge, deeth tion and/or Inv	occurred at the tir estigation, in my o	me, dete end pieca opinion, death occur	end due to the ce red at the time, de	ouse(s) and ma ate end piaca, a	nner as stel	ed.
or Attendiffer deat Director: in by the		29a. Certifier (Check only one) Car	Ical Exam	end manner of	HAIGO							ne cause(s)
or Attendent ifter deat Sirector: in by the	Medical Cer	Check only 2 Mac	Ical Exam	end manner s	stated.		29c. Licens	se number	26	d. Date signer	(Month D	
24 hours after deat Funeral Director: stely filled in by the	edical	29b. Signature and title of ce	rtifier	end manner s		1	-	_		od. Date signed		ay, Yeer)
or Attendent ifter deat Sirector: in by the	edical	29b. Signature and title of ce	rtifier	end manner s		)	-	_				ay, Yeer)
or Attending the deat Sirector: in by the	edical	29b. Signature and title of ce	rtifier S. rson who co	end manner s	deeth (Iten	n 23e) (Type, I Rock ature	Print)	_				ay, Yeer)

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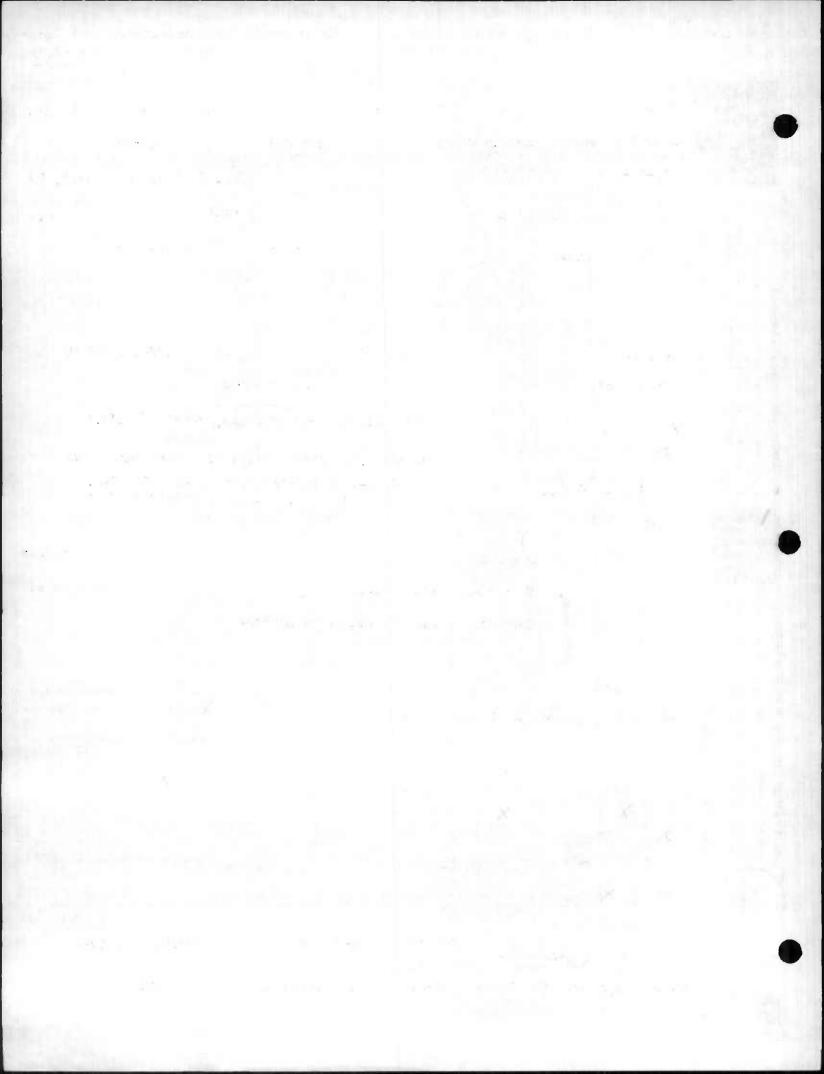


A	KER Items:	23a	part I 27 per MEO				nd / Depa <i>Cer</i>			lealth ar Death	nd Me	ental F	lygie Reg.		97	31	095
	Physic /Medi	ian	Decedent's Name (First, Mid BOBBY JC	dle, Last)		<i>y</i> (11)						. Date of Month	Death	Day	Year		of Death
P	Exami		4a. Facility Name (If not institution of the second of the						4	4b. City, Town		CTOL		12 1 4c. County BALTI		22:	02-PM
	Funeral Director		5. Social Security Number 212–88–6926	6. Sex 1 🗆 M	2 XF	'. Age (In yrs.	last birthday) 32 Yrs.	# Under	Days	If Under 24 Hours	Min.	. Date of (Month,	Day, Ye		9. Birthpl Count MARY		e or Foreign
	ylend	1	Usual Residence of Decedent  10a. State 10b. Coun	у		10c. C	ity, Town or Loc	ation				_	-	-	10	d. inside	City Limits
	ith the Maryler or 28a-f show	ctor	MD BAI	TIMOR	E		ESSEX								1 □ Yes 🎇		
	with th	Director	10e. Street and Number 51 WILTSHIRE	י פטער				10f. Zip	Code	212	21		10g.	Citizen of \	What Count	*	
	ms 23s	Funerai	11. Marital Status		Wes Deced	lent Ever in U		/as Dece	dent of H	ispanic Origin	n? (Speci	fy Yes or	No-	14. Rac	e - America		
5-0020	72 hours efter death with the Maryland "natural", or flems 23s or 28s-f show dost Examines must be nettred at	by	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rrled	Armed Ford 1 Tes 2 If Yes, Give Year or Dat	XNo	If	Yes, spe	cify Cubs	an, Mexican, F Specify:	Puerto Ri	can, etc.)			ck, White, e	etc.	
15-0	72 h	etec	15. Decede (Specify only high	nt's Educat	ion ompleted)		16e. Deced	aind of wo	rk done	during most o	f working		16b	. Kind of B	usiness/Ind		
2121		Completed	Elementery/Secondary (0-12)		College (1-	4or 5+)		CARE		VIDER				CHILD	REN		
aryland ?	be de la la la la la la la la la la la la la	o Be	17. Father's Name (First, Middle DON A. PALMER							18. Mother's	,			den Suman	7e)		
lary	d 2 should th and Men 7 Is marke traumatic	-	19a. informant's Neme/Relation	ship (Type,	Print)		19b. Mailing	Address	(Street	and Number	or Rural I	Route Nu	mber, Ci	ly or Town,	State, Zip	Code)	
e, M	is 1 and if Health Item 27 other tr		CHESTER E. AKE	RS, J	R/HUSI		51 W	_		ROAD	ESS	- 1	T	LAND			
altimore,	00-7		20a. Method of Disposition 1 → Burlal 2 □ Cremation		ovel from S		Plece of Dispos cemetery, crem	atory or c	other plac		1	Date	20c	. Location -	City or Tov	wn, State	
			4 <sup>th</sup> Donation 5 ☐ Other (			4Qi	AK LAWN			Y ss of Facility	10/1	6/97	BA	LTIMO	RE, M	ARYL	AND
-	permit. Departrimporta		> Curalui	RI	O.S.	16	1			. ZEILI	ER &	SON	, IN	c.			
	Physician		23a. Part1. Enterprise disease, shock, or least failure. Lis	or complicated only one	ions that ca cause on ea	used the dear ch line.	th. Do not ente	224 ] r the mod	EAST! le of dyin	ERN AVI g, such as ca	ENUE irdiac or	BAI respirator	TIM y arrest,	ORE,	- 1	224 Approxim Interval E Onset an	Between
	Physician /Medical Examiner	Н	Immediate Cause (Final disease or condition resulting in death)	a	ATH	EROSCLER	OTIC CAR	DIOVAS	SCULA	R DISEAS	E						
		-e	rodding in ddairy			Due to (	or es a consequ	uence of):									
,	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate	6	Due to (or as a consequence of):											m	
68760,	phy:	edicai	Cause (Disease or Injury thet initiated events  Due to (or as a consequence of):														
Box	death certifi e ettending rd for use es	M/us		d									-				
0.8	e death he ette ned for	Physician/M	Part II. Other significant condit	lona contrib	uting to dea	th but not res	sulting In the un-	derlying o	ause giv	en in Part I.		23b. D	ld tobac	co use co	ntribute to	the caus	of death?
1	es that the de											1	☐ Yes	2□ No	3 ☐ Prob	ably 4	Unknown
ecords,	requir been s should	Completed by										24a. W	as an au	itopsy	con	re autops ilable prio apletion of leeth?	
r	The law ete has b page 2 si	omp										1.1	Tes	2□No		/	□No
Vital	ysician: The s certificete director, par	Bec	25. Wes case referred to medic examiner?	al						26. Place of	f Death (	Check on	ly one)				
01	hysic this ce al dire	2	1X Yes 2□ No		pital: 1 ☐ In		ER/Outpatient	-		4 LI NUISI			_		er (Specify	)	
	ling F	ation:	E C / tooldon	ing tigation	28a. Date of (Month)	Injury Day Year)	28b. Time of Injury	M 2	28c. Injun Worl 1 □	yat k? Yes 2 □ No		d. Descrit	oe how in	njury occur	red		
Division		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	I not be	28e. Place o building	f Injury - At h g, etc. (Special	ome, farm, stre fy)	et, factory	y, office					er or Rural	Route N	ımber,	
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 Certify Medica	ng Physici i Examiner	an: To the b On the bas and manne	est of my kno is of examina or stated.	owledge, death ation and/or inve	occurred estigation	at the tim , In my o	ne, date and p pinion, death	occurred	d due to to at the tim	he cause ne, date	e(s) and ma and place,	anner as sta and due to	ated. the cause	9(s)
	withir To th	Me	29b. Signature and title of certifi	N <sub>e</sub>	111	00		290	c. License	e number			29d.	Date signe	d (Month, E	Day, Year	)
1			Mayne	tha	The	ll	,		OCME	3			00	CTOBE	R 13,	1997	7
			30. Name and address of person						14	+ 2	14.2				2122	•	
	Sta	ate	31. Date filed (Month, Day, Yea	-)	232. Re	distrar's Signa	ature	enn S	tree	et, Bal	TCTUK	ore,	Mary	y Land	2120	1	
	Registi		OCT 15 1997		Julia	lavidson-	Pandelle										

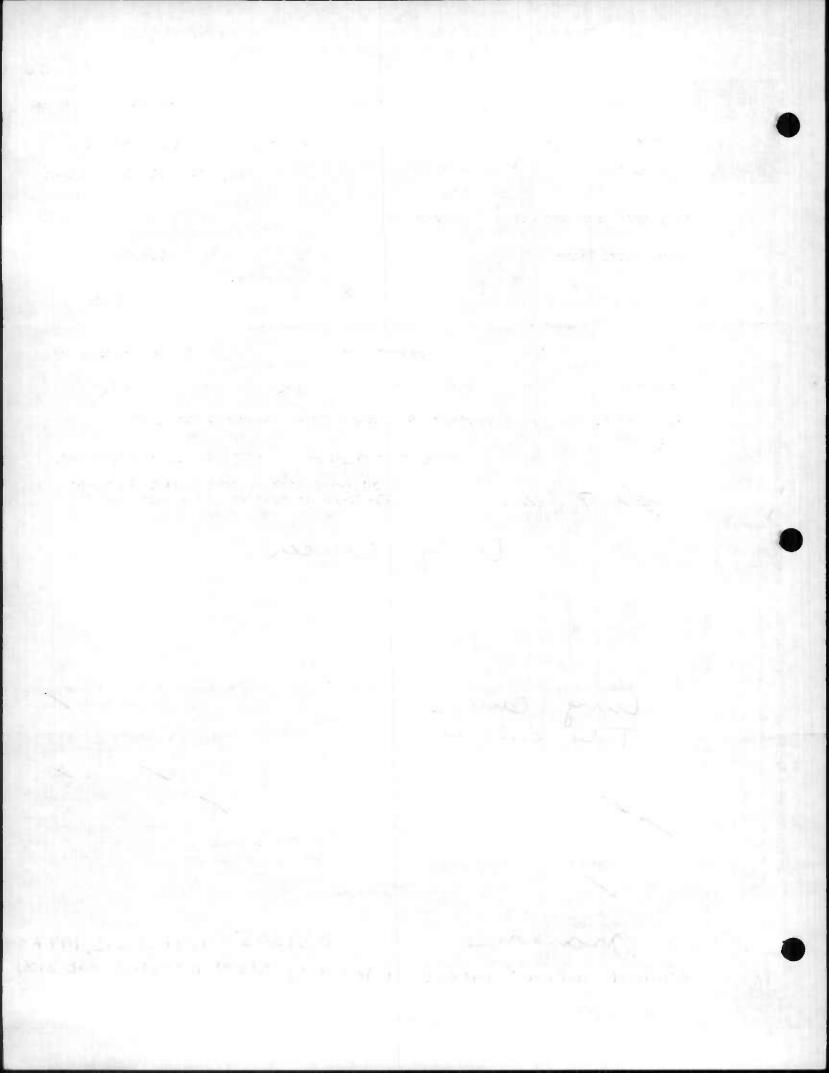
State of Maryland / Department of Health and Mental Hygiene 9.7

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		. Decedent's Neme (First, Middle,	, Last)	C =				Death	2.	Dete of Dee				Time of Death	
ician		Fountain				BEA	ŢĴ.		no	Month	Dey 10	Yes		20 A.M.	
dicai niner	10.0	a. Fecility Neme (If not institution,	, give street end num	ber)		DLL		4b. City, Town,				inty of De		20 A.H.	
	ı	Franklin Squar	e Hospital	L Cent	er			Roseda1	.e		Bal	timo	re		
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or	-	220-07-5392 Usual Residence of Decedent	IUM ZEAF	77	Yrs.				1, 1920	Conr	necticut
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	2	0a. Method of Disposition  1 Burial 2 Cremation	3 Removal from		ace of Disposition metery, cremetor	n (Neme of ry or other ple	ce)	Date	20c. Location -	City or To	wn, State
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edical Certification: To Be Completed by	2 2 2	5. Was case referred to medical examiner?  1 Yas 2 No  7. Manne of Death 1 Natural 5 Pendia Investi 3 Suicide 6 Could determ 4 Homicide  19a. Certifier (Check only one)  9b. Signature end title of cartifier  100. Name and eddress of person	Hospital:  28a. Date (Mon gation not be nined 28e. Placa building Phyalclan: To the Examiner: On the band man and man are the second se	Inpatiant 2 Inpatiant 2 Inpatiant 2 Inpatiant 2 Input	ER/Outpatient 3 28b. Time of Injury Name, farm, street, fa	DOA Oth  28c. Injur  Wor  1   1   1    factory, offica  curred et the tir getion, in my o	26. Place of De  ar: 4 Nursing i  y at  k?  Yes 2 No  me, dete and place pinion, deeth occur e number	24a. Was perf	yas 2 No  yas 2	24b. We ave cor of c	pably 4 Munknov  are autopsy findings aliable prior to mpletion of cause deeth?  3 Yes 2 No  4 Route Number, ated. the cause(s)



State of Maryland / Department of Health and Mental Hygiene 97

						(	Certifica	ate of	Death		Reg. No.	, ,	00004	
	Physic /Medi		Decedent's Name (First, Mide		nes A.	Brzozo	owski,	Sr.		2. Dete of Month		Yeer 1997	3. Time of Death 4:39	
	Exami		4e. Fecility Neme (If not institution Saint Jose			enter				or Location of De	eeth 4c. Coun	y of Deeth Balt	imore	
	Funeral Director		5. Sociel Security Number 215-09-7127 Usuel Residence of Decedent	6. Sex 1⊠M 2□ F		yrs. last birth	Month	der 1 Yeer ns Deys		Ain. (Month,	Birth Dey, Year) 30,1914		lece (State or Fore try) land	
SK!	Maryland a-f show iffed at	tor	10e. Stete 10b. Count	ne Arunde		. City, Town		adena	a			16	0d. Inside City Limi 1 ☐ Yes 2 2 N	
200	th with the 23e or 28 ant be not	al Director	10e. Street and Number 8390 Oak Dri	Ve			10f.	Zip Code	21122		10g. Citizen of	Whet Coun	try?	
32020WSK	2 hours after death with the Maryla atural", or thems 23s or 28s-f show ical Examiner must be notified at	by Funeral	11. Marital Stetus  1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	rried 1 Types	ecedent Ever Forces? s 2 No 1 Give r Detes: 1	in U,S. 1942 1945		cedent of pecify Cut		(Specify Yes or uerto Rican, etc.)	No- 14. Re BI Spec	eck, White, e		
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2 2	the state	Com	8	N/A		Che	emical	Eng:	ineer		Duj	pont		
A. Pu	tal Hyg d other event, I	Be	17. Fether's Neme (First, Middle						18. Mother's	Neme (First, Mide	die, Maiden Sume	me)		
y a		L <sub>o</sub>	Felix Brzozowski Eva Buczkowski  19e. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street end Number or Rural Route Number, City or											
Mary	2 sho													
1111 -	27 and 27		Margaret E. Hirshauer Daughter 8104 Frances Lane Pasadena, Maryland 2											
JAME Baltimore	Department of H Important: If the any injury or of 2008.		Margaret E. Hirshauer Daughter 8104 Frances Lane Pasadena, Maryland  20e. Method of Disposition  1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)  20b. Placa of Disposition (Neme of cemetery, cremetory or other piece)  Cedar Hill Cemetery Oct. 10, 1997  Baltimore											
	Physician /Medical Examiner		23e. Pert1. Enter the disease, c shock, or heert fellure. Lis Immediate Cause (Finel disease or condition resulting in deeth)	it only one ceuse or	PTIC 9	SCHOC	3204 t enter the m	Mount lode of dy	tain Roa		ena, Mar	yland	21122 Approximate Interval Between Onset end Deeth	
68760,	entificate be executed ling physicien and se as the buriel-trensit	cal Examiner	Due to (or es e consequenca of):  ISCHEMIC BOWEL  b. Due to (or es e consequence of):  RESPIRATORY FAILURE  C. Due to (or es e consequence of):									HOURS		
×	ndin Ise	in/Medical	resulting in deeth) Lest	d. REN	NAL FA	O (or es e co							WEEKS	
	death	Physician	Pert II. Other significant condit	ons contributing to	death but not	resulting In t	he underlyin	g ceuse g	iven in Pert I.	23b. D	id tobacco use c	ontributa to	the cause of deat	
s, P.C	as that the death cer igned by the ettendin be detached for use	by Phy	ATRIAL A	RRHYTHMI	A					1	□Yee 2□No	3 ☐ Prob	pably TUnkno	
Division of Vital Records, P.O.	been s	Completed	VALVULAR	HEART D	DISEAS	SE				24e. W	es en eutopsy erformed?	ave	ere autopsy findings sileble prior to mpletion of cause death?	
<u>=</u>	ysician: The lav is certificate hes director, pege 2	Con	CORONARY	ARTERY	DISEA	SE				1	☐ Yes 2 No	1□	Yes X No	
/ita	startific actor,	Be	25. Wes case referred to medic	al					26. Piece of	Deeth (Check on	ly one)			
=	Physic this co	2	1 ☐ Yes 2 No			2 ER/Outp	etient 3	DOA		g Home 5 R	esidence 6 🗆 O	ther (Specify	1)	
sion o	Attending Planding Plandeth.  Sctor: After the funeral by the funeral	Certification:	E ( ) 100100111	ng (Mo	te of Injury onth, Day Yea	28b. Tir Inju	ne of ury M	28c. Inju Wo 1	ury et ork? ] Yes 2 No	28d. Descrit	oe how Injury occu	irred		
Divis	tal or Attendent setter deet al Director: led in by the	Certific	3 Sulcide 6 Could 4 Homicide determ	mined 200. FIE	ce of Injury - / Iding, etc. (Sp	At home, fern ecify)	n, street, fact	ory, office		28f. Location City or	n (Street end Nun Town, Stete)	ber or Rura	Route Number,	
	To the Hospital or Attending Ph Mithin 24 hours efter deeth. To the Funeral Director: After thi completely filled in by the funeral	Medicai	(Check only 2 Medica one)		he best of my basis of examenner stated.	knowledge, onlinetion end/	or Investigati	on, in my	opinion, deeth o	eca, end due to t courred et the tim	he ceuse(s) end n ne, dete end piece	nanner as st , and due to	eted. the ceuse(s)	
1 4	200	2	29b. Signeture end title of certifier  29c. License number  29d. Date signed (Mon									Jey, Year)		
	0		Michera	راب لــا،	NAVI	cuu		1.	031826		10-0	e-T	1	
-	PIVI		30. Name and address of person RICHARD L.	LINTHI	CUM, N	M. D.		YORK	K ROAD	TOWS	ON, MARY	LAND	21204	
	Sta Registr		31. Dete filed (Month, Say 199)	Fish	Registrar's S	igneture	AC							

State Registrar .....

Tributal Section 1

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(Market III)

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BEACH THE RESIDENCE OF THE LOCAL PROPERTY OF THE PROPERTY OF THE PARTY

THE PERSON NAMED IN COLUMN

385250 - 58686

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month **Physician** Oct apple 2 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Center

5. Social Sacurity Number

6. Second Sacurity Number

16. Second Sacurity Number ed. BAlf: 7232 Jerman Hill Baltimore 1 MER-C 24 Hrs. 8 9. Birthplaca (Stata or Foraign Country) 6. Sax 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1 M 25 F 216-07-0597 79 Yrs **Director** Jan. 13, 1918 Maryland Usual Rasidanca of Dacedant the Meryland r 28a-f show 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Md. Baltimore Essex 1 ☐ Yas 21 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? item 27 is marked other than "netural", or items 23a or other traumatic event, the Medical Explainer mail be. 1602 Howard Ave. 21221 USA Funeral 12. Was Dacedant Evar In U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - American Indian, Black, White, atc. 11. Marital Status 2 should be filed within 72 hours efter end Mental Hygiene. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 No Specify: þ Specify: White 3₺ Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) **Hutzler** Supervisor 11th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be William Miller 2 Annie Amos 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Pages 1 end 2 s ment of Heelth er Important: If itam 27 any injury or other tr Linda Althoff/daughter 5312 Bangert Street White MArsh Md. 21162 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Department 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Cemetery 10/15/97 Baltimore Md. 21. Signatura of Funaral Sarvica Licenses 22. Nama and Addrass of Facility Connelly Funeral Home of Essex Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. 300 Mace Ave. Baltimore Md. 21221 Approximata Intarval Batw Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) OCAR DIAC NEARCZION Examiner Examiner physician and the burief-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical to (or as a consaquance of) 50 signed by the et d be detached fo Part II. Other aigntiticant conditions contributing to death but not resulting in the underlying ceuse given in Part i. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 ☐ Unknown Division of Vital Records. by 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy parformed? Completed peen hes page 2 2 1100 certificete 1 Yas 1 Yas 2 No Hospital or Attending Physician: funeral director. 25. Was cesa rafarred to medicel axaminar? 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 100 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Yaar) 27. Manney of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Natural 5 Panding death. 1 ☐ Yas 2 ☐ No Invastigation ofter death Director: / 2 Accidant 6 Could not be datarmined 3 ☐ Sulcide 28f. Location (Streat and Number or Rural Routa Numbar, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Cartifiar Medical completely 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Yaar) 30. Nama and addrass of parson who complated cassa of death (Itam 23a) (Type, Print) 3927, ANNAPOLIS LOND 21227. +SHOK K CHATTENJEE

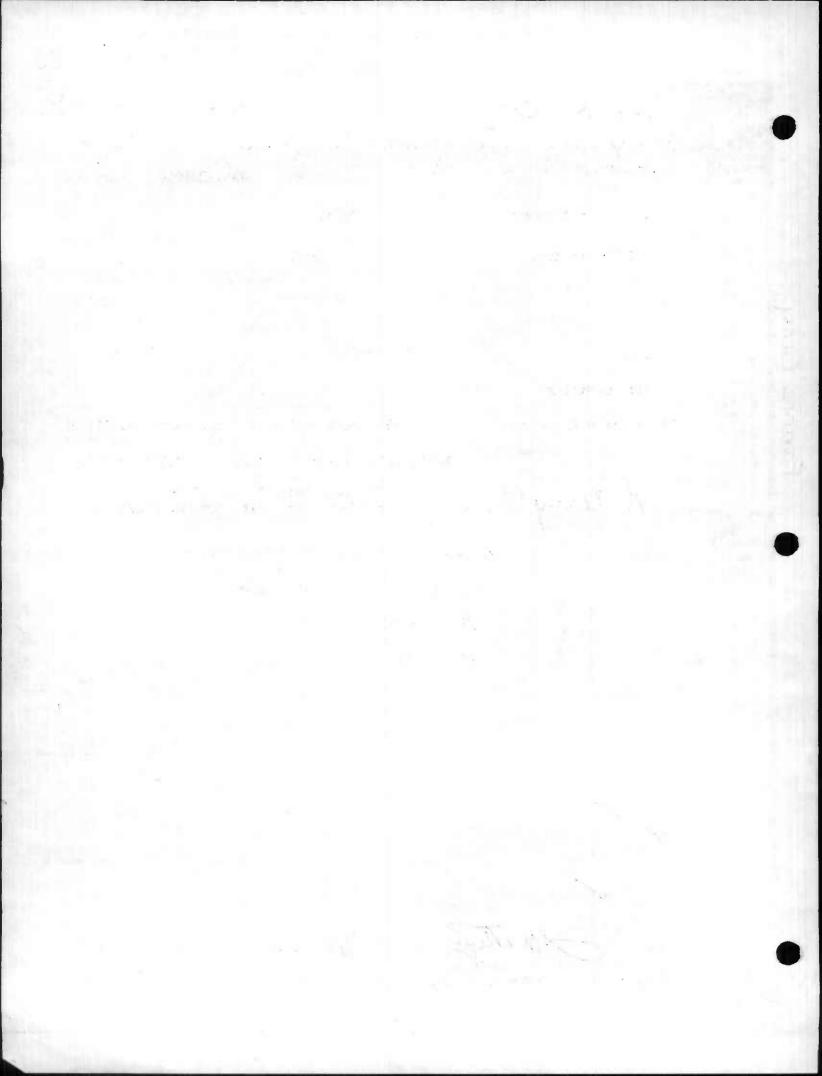
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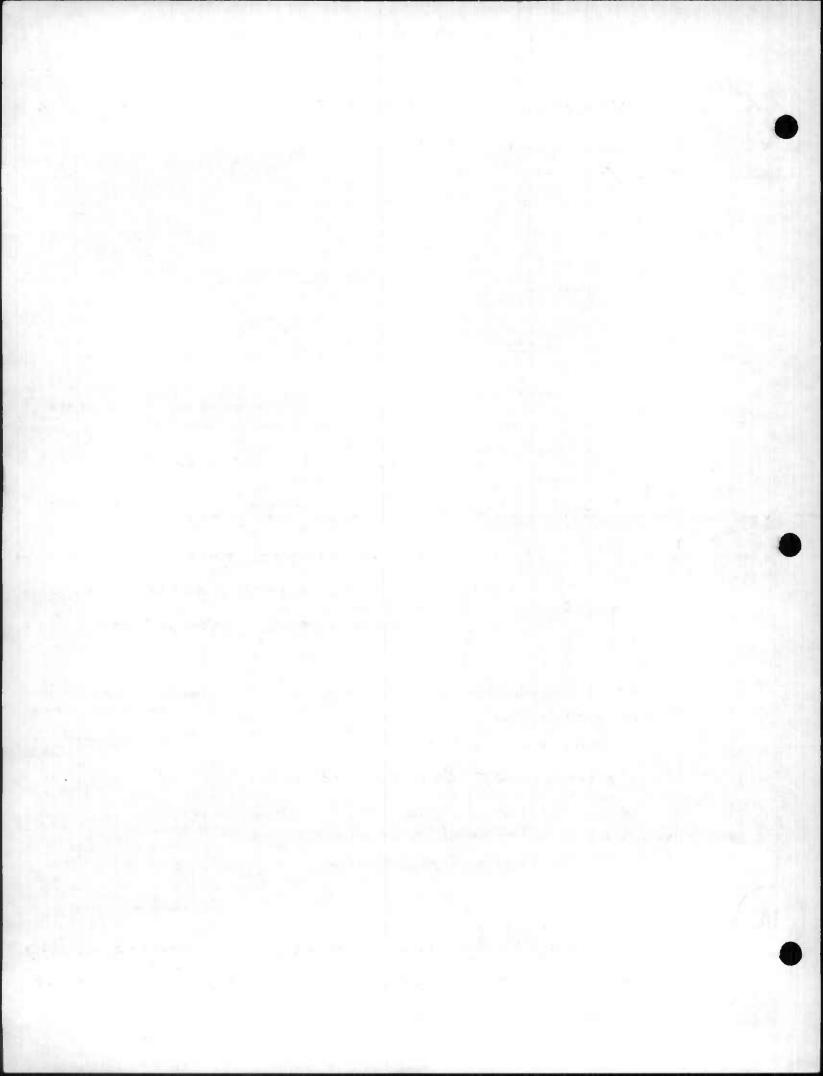
31. Data filed (Month, Day, Yaar) OCT 1 5 1997

Ragistrar's Signatura L. Savidson



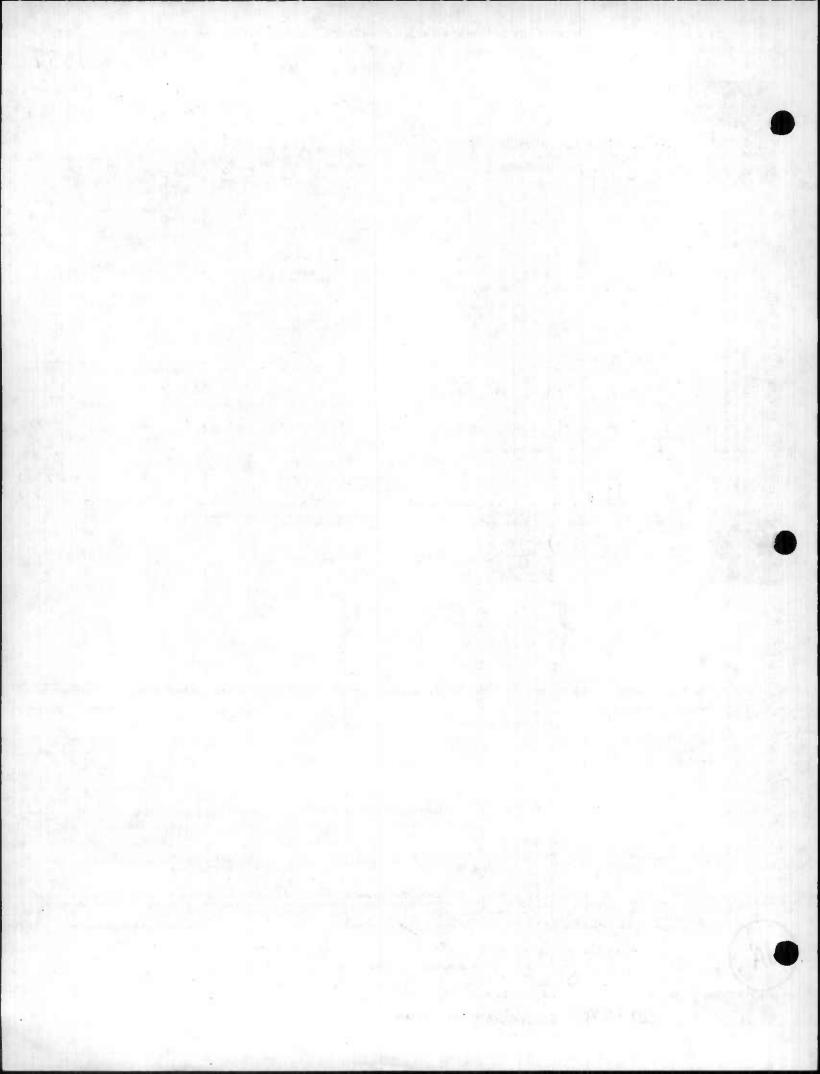
State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Re	eg. No.	1 3093
hysicia	n	1. Decedent's Name (First, Middle, Last)	1 PANIDED	2. Dete of Deat Month	h Dey Y	3. Time of Death
Medica xamine	al	VERNIECE D.  4e. Facility Name (If not institution, give street and number)	CROWDER  4b. City, Town, or L	oction of Death	4c. County of	Death
ai or		219-32-558/ 10 M 21XF 6	yrs. last birthday) If Un r 1 Y r If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 3-24-	Year)	Birthplace (State or Forei
			c. City, Town or Location			10d. Inside City Limi
	Director	10e. Street and Number	Baltimore 101. Zip Code	10	0g. Citizen of Wha	
	a	3922 Grantley KC	in U.S. 13. Was Decedent of Hispenic Orlgin? (Se	pecify Yes or No-	14. Race -	S. A American Indian,
-	p	Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	in U,S.  13. Was Decedent of Hispenic Origin? (Spif Yes, specify Cuban, Mexican, Puerto  1  Yes 2 No Specify:	o Rican, etc.)	Specify:	White, etc. Black
	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work liffe. DO NOT use retired)	king	21	e Securit
1	Be	17. Eather's Name (First, Middle, Last)	Claims Adjust	ne (First, Middle, M	Malden Sumame)	stration
F	٥	19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Ru	ral Route Number,		1a // y ete, Zip Code) 3840/-
		1 Burial 2 ☐ Cremetion 3 ☐ Removal from State	122 SH Margareth  Db. Place of Disposition (Name of carmetery, cremetory or other place)	Date	20c. Location - Cit	y or Town, State
NIING:		21. Signature of Funeral Service Licensee	22. Name and Address of Facility  March  7. H. W.		ansca j	1 stown, nd 2121
ı	1	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one ceuse on each tine.	death. Do not enter the mode of dying, such as cardiac	or respiretory arre	enue i	Approximate Intervel Between
ın ai		tmmediate Cause (Final disease or condition P035	IBLE MYOCARDIAL	TNE	ARETIO	Onset and Death
r	_	Due	to (or as e consequence of):	1		73 ///
	Examiner	D	21'05CLEROTIC HEAR	-T D15	EASE	unknou
	EX	Sequentially list conditions, if any, leading to Immediate	to for as a somewheres one			1
		cause. Enter Underlying		LNNG	- ASE	ASE "
	Medicai	cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Lest  Due to	NI'L OBSTRUCTIVE to (or as a consequence of):	LMNG	- ABE	ASE 4
	Medicai	cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest  d.	NI'L OBSTRUCTIVE to (or as a consequence of):			
Designation	Physician/Medicai	cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest  C. HROT  Due t  d	NI'L OBSTRUCTIVE to (or as a consequence of):	23b. Did to	bacco use contri	bute to the cause of deet
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Parister Director	by Physician/Medicai	Cause (Disease or Injury that Initiated events resulting in death) Lest  C. CHRON  CHRON  Due to the condition of the conditi	to (or as a consequence of):  to resulting in the underlying cause given in Pert I.	23b. Dld to 1	bacco use contri	bute to the cause of deat  Probably 4 Unkno
Social, paga z snould be detached for use as me	Be Completed by Physician/Medical	Cause (Disease or Injury that Initiated events resulting in death) Lest  Part II. Other significant conditions contributing to death but not  - HYPERTENTION  - DIAISETES  ABSCESS RT  25. Was case referred to medical examiner?	to (or as a consequence of):  to resulting in the underlying cause given in Pert I.  ELLITUS  GLUTEAL MUSCLE  28. Place of Dea	23b. Did to  1  Ye  24a. Was ei perform  1  Ye  th (Check only one	becco use contri	bute to the cause of deet Probably 4 Unknow  24b. Were autopsy findings available prior to completion of cause of deeth?  1 Yes 2 No
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Addad Carellane To De Commission In Division Meads	Medical Certification: 10 Be Completed by Physician/Medical	Cause (Disease or Injury that Initiated events resulting in death) Lest  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant conditions contributing to death but not d.  Part II. Other significant co	to (or as a consequence of):  It resulting in the underlying cause given in Pert I.  ELLITUS  GLUTEAL MUSCLE  28. Place of Dea  2 ER/Outpatient 3 DOA Other: 4 Nursing Harry  1 Yes 2 No  At home, farm, street, factory, office  knowledge, death occurred at the time, date and place, mination and/or investigation, in my opinion, death occur	23b. Dld to  1 Ye  24a. Was er perform  1 Ye  th (Check only oncome 5 Reside 28d. Describe ho  28f. Location (Sh. City or Town)  and due to the carred at the time, de	bacco use contri	bute to the cause of deat  (Probebly 4 Unknow  24b. Were autopsy findings available prior to completion of cause of deeth?  1 Yes 2 No  (Specify)  or Rural Route Number,  er es stated. I due to the cause(s)
DEFINITION IN MANY IN STREET, page 2 should be detached for use	Medical Certification: 10 Be Completed by Physician/Medical	Cause (Disease or Injury that Initiated events resulting in death) Lest  Part II. Other significant conditions contributing to death but not	to (or as a consequence of):  It resulting in the underlying cause given in Pert I.  ELLITUS  GLUTEAL MUSCLE  28. Place of Dea  2 ER/Outpatient 3 DOA Other: 4 Nursing Harry  1 Yes 2 No  At home, farm, street, factory, office  knowledge, death occurred at the time, date and place, mination and/or investigation, in my opinion, death occur	23b. Dld to  1 Ye  24a. Was er perform  1 Ye  th (Check only oncome 5 Reside 28d. Describe ho  28f. Location (Sh. City or Town)  and due to the carred at the time, de	bacco use contri	bute to the cause of deat  (Probebly 4 Unknow  24b. Were autopsy findings available prior to completion of cause of deeth?  1 Yes 2 No  (Specify)  or Rural Route Number,  er es stated. I due to the cause(s)



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 30957

		Certificate of Death	Reg. No.	30931
Physician	Decedent's Nama (First, Middla, Last)	Par	2. Data of Death  Mognity  Day  Veget	3. Time of Death
/Medical Examiner	4a. Facility Nama (If not institution, give streat and number)  MARYLAND C7ENERAL HOSP  5. Social Security Number  6. Sex  7. Aga (In yrs. las	4b. City, Town, or Lo  Paul Amon t birthday) If Undar 1 Yaar   If Undar 24 Hrs.	Re Crty NA	
Funeral Director	2/3-28-/320 1 M 2XF 69 Usual Residence of Decedent	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birth Co	tholace (Stata or Foraign junity)  M. d.
tal Hygiene in a record street death with the maryland of other than "natural", or items 23s or 28s-1 show event, fre Medical Exercises must be notified at Be Completed by Funeral Director	Md NA Ba	Town or Location (+1 more		10d. Inside City Limits 1 2√Yas 2 □ No
r frems 23a or 28a-f s finer mant be notified Funeral Director	100. Street and Number  M40 Poplar Grove Street	101. ZIp Code 2/2/6	10g. Citizen of What Co	A P
ral, or items 23a or 28a-1 show Exactine mant be notified at 1 by Funeral Director	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Evar in U,S. Armed Forces?  1 Yes 2 Vivo If Yas, Give Year or Datas:	13. Was Decadent of Hispanic Origin? (Spriff Yes, specify Cuban, Mexicen, Puarto 1 □ Yes 2 No Specify:	ecify Yas or No- Rican, etc.)  14. Raca - Ama Black, White  Specify:	
ygiene. ner than "natura t, tre Weolcal Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Grade  Upan	16a. Decedent's Usual Occupation (Giva kind of work dona during most of work) ilite. DO NOT usa ratired) Teacher's Aid	16b. Kind of BusinessA SChool	Industry
and Mental Hygiene. sumatic event, tress To Be Comp	17. Father's Name (First, Middle, Last) William Cecil Widgeo	n Glade	e (First, Middle, Malden Sumame)	
of Health I Item 27 I	Martina Ellis - God Daughter  20a. Method of Disposition  20b. Plac cem  20b. Plac cem	19b. Malling Address (Street and Number or Plure 331 N. Monroe se of Disposition (Nama of atan, cramatory or other placa) Addawn leyetery 1	Street Balto  Data 20c. Location - City or  0-17-97 Balto mor	town, State
Department of I Important: if Ite any Injury or o once.	21. Signature of Funeral Service Licensee	22. Nama and Address of Facility	it hash sueme	21217 Bo 140 Md
nysician	23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart feilure. List only one ceuse on each line.	Do not entar tha moda of dying, such as cardiac of	or raspiratory arrest,	Approximata interval Between Onsat and Death
Medicai xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Myo Caudo Control of the condition resulting in death)	al Intarction s a consequence of):	- I	1 month
e etending physician end ad for use as the burial-transit sician/Medical Examiner	If any, leading to immediate cause. Enter Underfuling Cause (Disease or injury that initiated experts.	s a consequence of):		
ed by the ettendi deteched for use y Physician/	Part II. Other significant conditions contributing to death but not resulting	ig In the underlying ceuse given in Part t.	23b. Did tobacco uee contribute	
be d	CONDIAC ARREST		1 Yee 2 No 3 Pr	•
ate has been signed by the page 2 should be deteched			performed?	Were autopsy tindings available prior to complation of cause of death?
Be	25. Was cese reterred to medicet examiner?  Hospitel: Hospitel:	Other	(Chack only ona)	
h. After thi funeral tion: 7	27. Menpér of Death 1 Monpér of Death 1 Monpér of Death 1 Monpér of Death 2 Sa. Date of Injury (Month, Day Year) 2 Accident investigation	Outpatient 3 DOA 4 Nursing Hor	me 5 ☐ Residence 6 ☐ Other (Spec 28d. Describe how injury occurred	oify)
ours efter deatheral Director: filled in by the	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street and Number or Ru City or Town, Stata)	iral Routa Number,
pletely pedic	29a. Certifier (Check only one)  1 ✓ Certifying Physician: To the best of my knowled 2 ☐ Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place, a and/or Investigation, in my opinion, death occurred	and due to the cause(s) and manner as ed at tha time, date and place, and dua	stated. to the cause(s)
W N	29b. Signature and tiller of contribut	29c. License number 89276	29d. Data signed (Month)	n, Day, Year)
)	39 Name and address of person who completed cause of death (Item 23 Kuphalk Sman, M.D. Ch	e) (Type, Print) Miduland CreneRi	al Hospital.	
State Registrar	31. Date filed (Month, Day, Year)  OCT 1 5 1937  July Mandeon—Ro	inde 88		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Dete of Daath **Physician** October 3 1999 B. HNNA 08:02am /Medical 4e. Fecility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Deeth **Examiner** Greater Baltimore Medical Center Towson Baltimore 5. Sociel Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sax 8. Data of Birth (Month, Day, Year) Nov. 24, 1915 9. Birthplace (State or Foreign Country) Sax 1□M 2 F 171-22-1785 Usual Rasidanca of Dacedant 10b County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2□No Director ARMSTRONG FORD 10e. Straat and Numbar 10g. Citizan of What Country? 700 REAL GTH AVE. 16226 U.5.A Funeral Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 1 Navar Marriad 2 Married 1 Yes 2 No If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Dacedant's Education (Specify only highest grada completed) 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOME MAKER OWN HOME 12 17. Fether's Nema (First, Middla, Last) 18. Mother's Nema (First, Middle, Meidan Sumema) JOSEPH LUSAR MARY ZAKOTCANIK 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, State, Zip Coda) 700 REAR GTH AVE. FORD CITY PA. 16226
Data 20c. Location - City or Town, Stete MICHAEL 20b. Plece of Disposition (Nama of cematary, cramatory or other place) OCT. 7 1997 20a. Mathod of Disposition 1 Burial 2 Crametion 3 Ramoval from Stata FORD CITY, PA 4 □ Donation 5 □ Othar (Spacify) 22. Nama and Address of Facility 2829 HUDSON 21. Signature of Funaral Sarvice Licensaa BALTIMORE, 23a. Pert1. Entar tha disaase or complications that ceused the death. Do not antar the mode of dying, such as cerdiac or respiretory errest shock, or heart failure. List only one cause on each line. Immediata Cause (Final Cardio GRNic disaasa or condition rasulting in deeth) Dua to (or as a consequence of): focurdial Sequentially list conditions, if any, laading to Immediata ceuse. Enter Underlying Causa (Disease or injury that initiated avants rasulting in death) Lest Dua to (or as e consequance of): Part ii. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Carcinoma 24b. Wara autopsy findings available prior to complation of ceuse of daath? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarrad to madicel examinar? 26. Place of Daeth (Check only one) 1 Yas 3 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatiant 3 DOA 28c. Injury at Work? 27. Mangar of Death 28d. Describe how Injury occurred 28b. Time of 1 Natural 2 Accident

Examiner Records, P.O. Box 68760, After this cartificate has Division of Vital hding Physician:

**Funeral** 

Director

important: if item 27 is marked other than any injury or other traumatic event, the Ma

**Physician** /Medical

> Physician/Medical Examiner Completed Be Medical Certification: To 3 ☐ Suicide 4 Homicide

5 Panding Invastigation

6 Could not be datarmined

tuarnien

28a. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata) Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mennar as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura end titla of certifiar

MD

29c. License number

N Charles ST.

29d. Dete signed (Month, Day, Yaer)

30. Nama and eddress of person who completed causa of deeth (Itam 23a) (Type, Print) Thomas 31. Dete filed (Month, Day, Year)

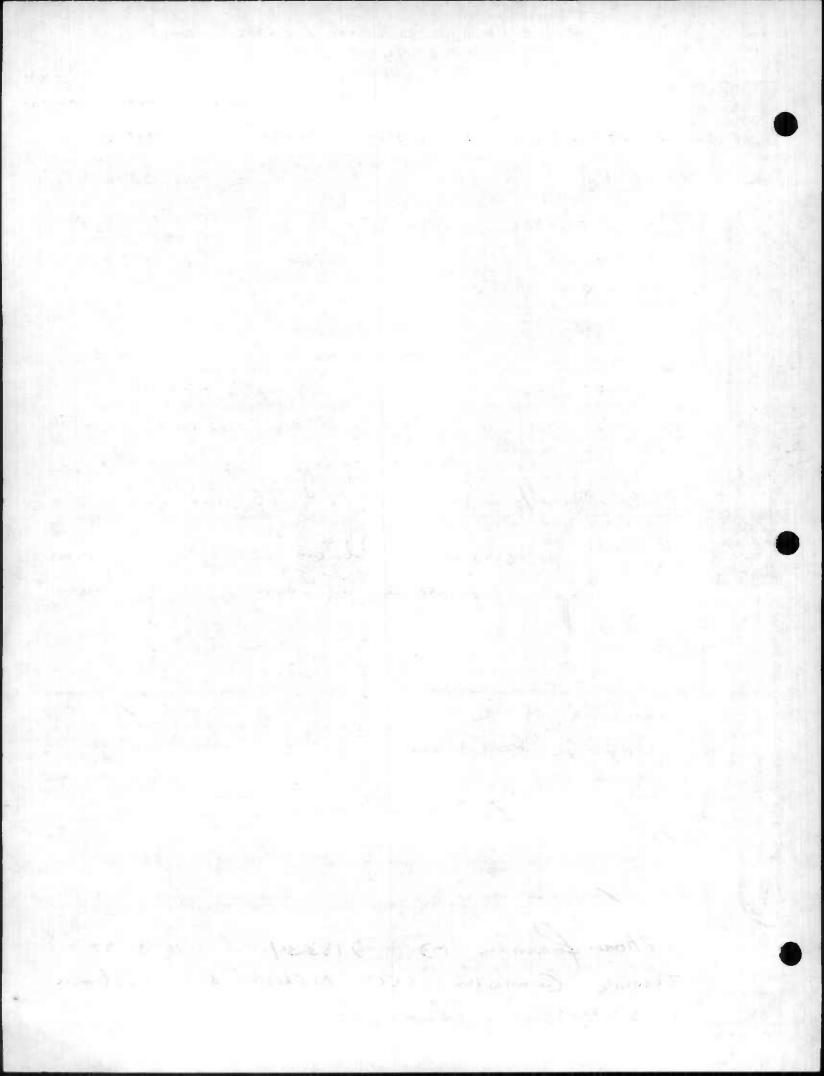
(0-3-5 DCT 1

Guarvien 32. Ragistrer's Signature

6569

DHMH 16 Rev 6/95

Registrar



### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First Middle Last) 2. Date of Death Cross Month Edward DIAND 230 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ASAGENA If Under 24 Hrs. 8. Date Hours Min. (Mon lichols on )r. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 № M 2 🗆 F Months Days Yrs. 212-20-3035 Feb. 3, 1926 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 25 Nicholson Drive 21122 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 TYes 2 No 1947 If Yes, Give Year or Dates: 1050 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced Specify: White 1950 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Air Condition, Refrig. Technician Acme Markets N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Edwin John Cross Celia May Sauers 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mary Cross 25 Nicholson Drive Pasadena, Maryland 21122 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Meadowridge Mem. Park Oct.8,1997 Baltimore, Maryland 21. Signature of Funda Service Licens 22. Name and Address of Facility McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause of each lina. Immediata Cause (Final disease or condition resulting in death) UNK pertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Pul movery 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Daath (Chack only one) examiner? Other: 4 ☐ Nursing Home 5 1 Desidence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Anatural 5 Pending Investigation 1 Tyes 2 No 2 Accident

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 5 差 Atter Attending Director: To the Hospital

**Physician** 

/Medicai

Examiner

**Funeral** 

Director

28a-f show

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Herns 23a

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"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiane. Important: If item 27 is marked other than any injury or other traumatic event.

**Physician** /Medical

Examiner

Director

by Funeral

Completed

Be

2

Physician/Medical

ģ

Be Completed

To

Certification:

Medical

traumatic event, the Medical Examiner must be notified at

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0020

25. Was cese rafarrad to medicel examiner? 27. Manner of Death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicida 1 Cartifying Physician: To the best of my knowledge, daath occurred at the time, data and piace, and due to the causa(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a, Certifier (Check only one)

29b. Signature and title of certifier

Deputy

29c. License number 29d. Date signed (Month, Day, Year)

and addrass of person who complated cause of death (Itam 23a) (Type, Print)

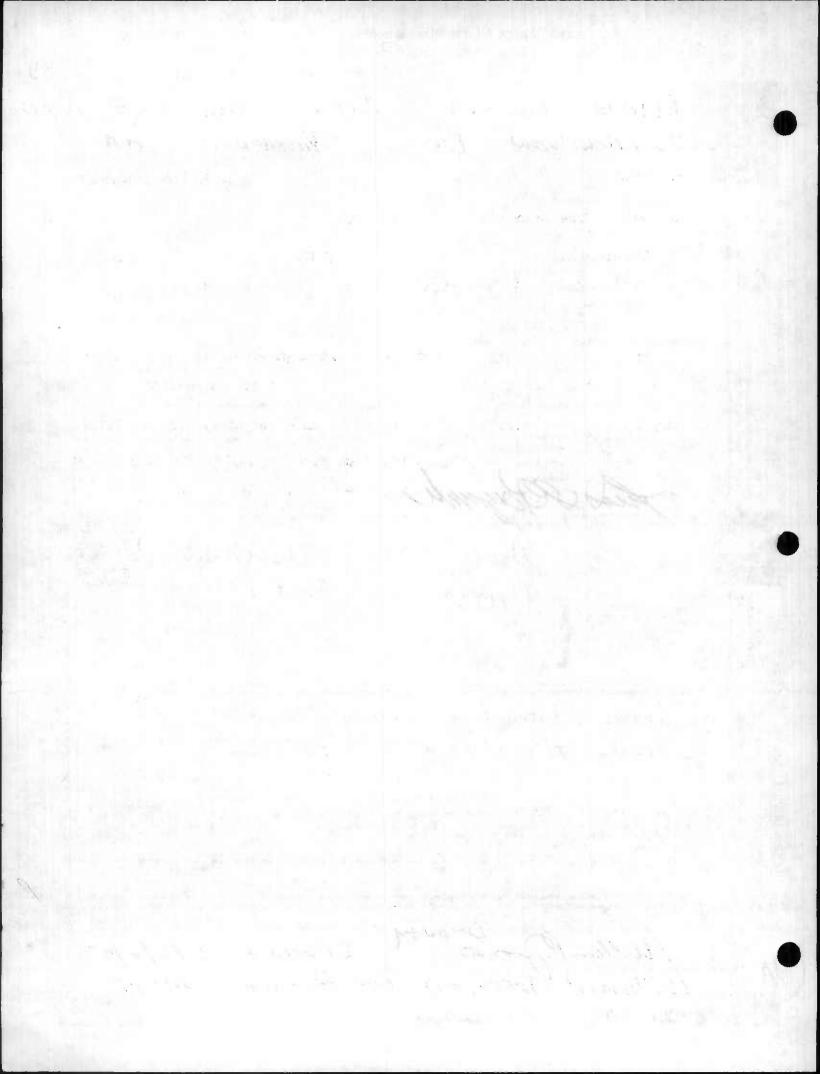
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DNES MI 32. Registrar's Signature

State Registrar

within 24 to To the Fur completely



State of Maryland / Department of Health and Mental Hygiene 97

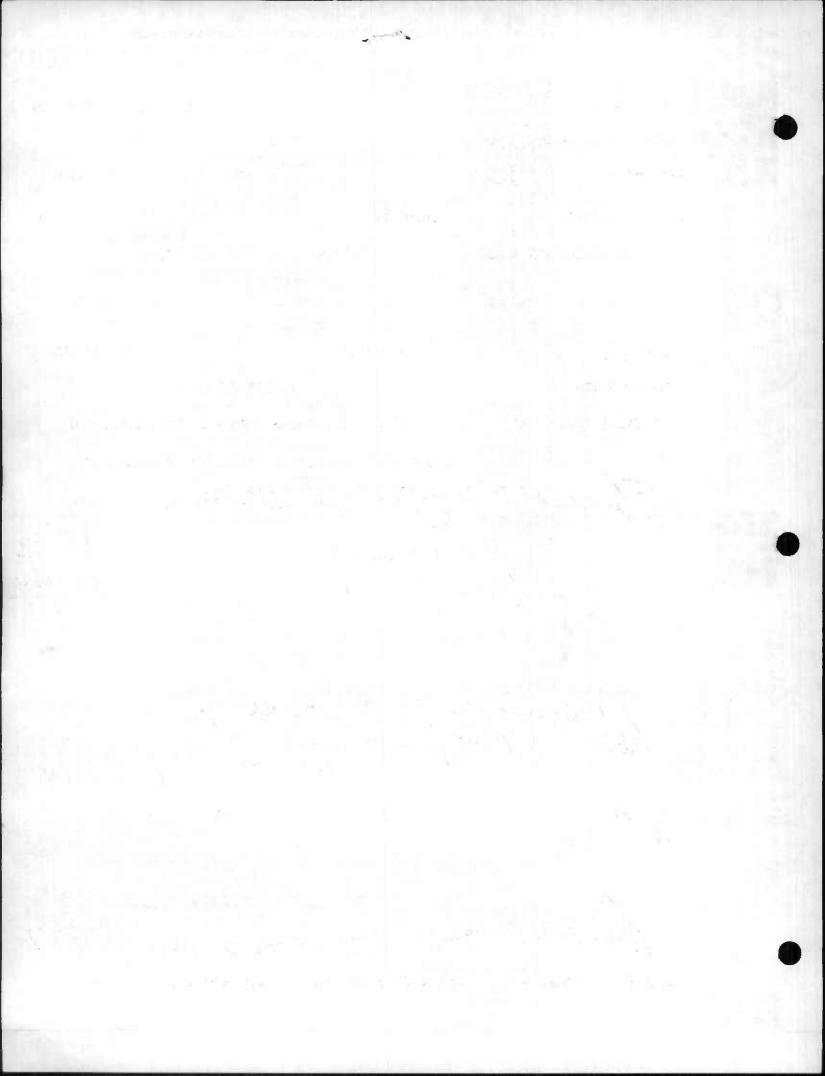
Certificate of Death

30960

						Ce	runcai	e or	Death			Reg.	No.		
Physic		1. Decedent's Nan REKA CH	na <i>(First, Midd</i> la, L LANEY	.ast)							2. Date of D Month OCTOE		Day 10, 1	Year 1997	3. Time of Death 1:00 AM
/Medi Exami			(If not institution, g							own, or L	ocation of Dea	ath	4c. Count	y of Death	
Funeral Director		5. Social Security   223-26-5	738	Sex 1□ M 2⊠ F	7. Age (In yrs. l. 85	last birthday) Yrs.	If Under Months			24 Hrs. Min.	8. Data of E (Month, I AUG	Sirth Day, Ye 2, 19	ar) 912	9. Birth	placa (Stata or Foraign Intry) TVIRGINIA
ith the Maryland or 28a-f show as notified at	or	Usuai Residence o 10a. Stata MD	10b. County HOWARD			r, Town or Lo					116				10d. Inside City Limits 1 ☐ Yas 2 (X) No
the 128m	rect	10e. Street and Nu	umber				10f. Zip	Code				10a.	Citizen of	What Cou	ntry?
23a or ust be	Ö	8291 OLI	D MONTGON	MERY ROA	AD			2104	.5				U.S.A.		
0020 hours after death with the Maryla ursh, or Hems 23e or 28e-f sho at Examiner must be notified at	by Funeral Director		ried 2 Married	Armed F	20 No live		Was Deced if Yes, special				ecify Yes or No Rican, atc.)	No-		ick, Whita,	ican indian, , atc.
ST215.0	Completed	(Spe Elementary/Sec 5TH GRA		rada complated	) (1-4or 5+)	lifa.	dant's Usua kind of wo DO NOT us MEMAK	ork done sa ratin	during mos	st of work	sing	16b	. Kind of B	HOM	ndustry MEMAKING
	To Be	17. Fathar's Nama WILLIAM	(First, Middle, Las SMITH	61)							e (First, Midd			ma)	
And and and is me		19a. informant's Name/Relationship (Type, Print)  MAE BOWERS (DAUGHTER)  19b. Mailing Address 8291 OLD							at and Numb	er or Rui	ral Routa Num	ber, Ci	ty or Town	, Stata, Zij	p Code)
and and mazz				GHTER)	1-41 -				TGOME	RY R				-	
Baltimore, semit. Pages 1 a Department of He mportant: If Nem nny Injury or othe ands.			sposition Cremation 3 5 Other (Spec		Stata	laca of Dispo ama <i>t</i> a <i>ry, cre</i> r ADOWRI	natory or o	othar pla		PK	Data 10/13/9			- City or To	own, State
Balt permit Depart import any in		21. Signature of E	un dal Sarvice Lica	ansaa	They	MI	BBAR	D FU		HOM	Æ INC.		F MI		1229
Box 68760, ath certificate be executed Wedging physician and for use as the burial-fransit	lan/Medical Examiner	shock, or her shock, or her shock, or her shock, or her disease or condition resulting in death)  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	onditions, mmediata erlying r injury	a. b. c.	Due to (or Due to (or	r as a consec	quance of):	ia		cardiac	or raspiratory	arrast,			Approximata interval Between Onsat and Death  3
15, P.O. Bo	Physicia	Part II. Other signi	ificant conditions	contributing to	death but not rasu	Ilting In the u	ndertying o	euse g	iven in Part	1.	23b. DI	d tobac	co use co	ontribute t	to the cause of death'
P. hat the		1	Elevie	osile	rotic	He	out	X	Juse	186	2 13	Yes	2□ No	3 Pro	obably 4 Unknow
I Record The law requi	Completed by	Al	domin	inl p	lassy	nobr	ble	AV T	Wel	Lou		as an au rformed	200 No	av of	Vara autopsy findings vallable prior to ompletion of causa f death?
Vital Fideler: The certificate inector, page	Be	25. Was casa refe examiner?	V	Hospital:				0	ther		th (Check only	y ona)			
Division of Vita Within 24 hours effer death.  To the Funeral Director: After this certification the Funeral Director: After this certification placety filled in by the funeral director,	ation: To	27. Mannar of Dea 1 Natural 2 Accident	5 Panding investigation	28a. Data (Mo	inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing I of injury of injury oth, Day Year)  28b. Time of Injury M 28c. injury at Work? 1 Yes 2 No						fome 5 Assidence 8 □Other (Specify)  28d. Describe how injury occurred			<u>(y)</u>	
Division To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Sulcide 4 ☐ Homicida	6 ☐ Could not determine	d Zoa. Plac	a of injury - At ho ling, atc. (Specify	me, farm, str	eet, factor	y, office	)		28f. Location City or 7			ber or Rur	ral Routa Number,
Hosp. 24 hou Funer	edicai	29a. Certifier (Check only one)	Certifying P	miner: On the I	a best of my know basis of examinati nnar stated.	vledga, daati ion and/or in	occurred vestigation	at the t	ime, date ar opinion, dat	nd place, ath occur	and due to the red at tha time	a caus a, data	e(s) and m and place,	annar as a , and due t	stated. to the cause(s)
To the within To the comple	Mec	29b. Signature and	title of certifier	am	MM_		290	c. Lican	se number	40	3	29d.	Data sign	ed (Month,	Day, Year) 7
5		30. Name and add									morran			2.5	00
		DR. ATIQ	UR RAHM	AN 71	6 MAIDEN	CHOI	E LA	NE -	-LL-1	- CA	ATONSVI	LLE	, MD	212	28
Sta	ate	31. Date (10)	5 1997 ar)	Junear	MAGINETICAL PROPERTY	UTU									

DHMH 16 Rav 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Deta of Deeth **Physician** Joseph Dimarco 11:00AM 4b. City, Town, or Location of Deeth 4c. County of Death /Medical 1997 4a. Fecility Name (If not institution, give street and number) Examiner 7562 Westfield Road Dundalk Baltimore 5. Sociel Sacurity Number If Undar 1 Yaar if Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 10℃M 2□ F Months Deys Hours Yrs. Director 218-28-0828 64 Dec. 28,1932 Maryland Usual Residence of Decedent tha Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23e or 28e-f show traumatic event, the Macical Examinar must be notified at Maryland Baltimore Dundalk 1 ☐ Yes 2 Ø No Director 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 7562 Westfield Road 21222 United States Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No If Yes, Giva Yeer or Dates: 1953-55 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours aftar 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yee 2 ☐(No Specify: À Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry permit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "reament over the Mental Philury or other traumatic event, the Macobies. Eiementery/Secondery (0-12) College (1-4or 5+) 8 Years Supervisor County Utilities 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be Joseph Dimarco 2 Bessie Robertson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) Mrs. Eve-Ann E. Dimarco/Wife 7562 Westfield Road Dundalk, Maruland 21222 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burlai 2 ☐ Cremetion 3 ☐ Removal from State 4 Donetion 5 Other (Specify) Gardens of Faith Cemetery 10/1/1997 Rossville, MD 22. Name end Addrass of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Entar the diseesa, or complications that caused the shock, or heart feilure. List only one cause on each line. ath. Do not anter the mode of dylng, such es cardiac or respiretory errest, Onset end Deeth **Physician** immediete Ceuse (Finel disease or condition resulting in deeth) /Medical Myocardial Infarction Examiner Due to (or es e consequence of) siclan and burial-transit Sequantielly list conditions, if any, leeding to immadiete cause. Enter Undarlying Ceuse (Diseese or injury that initieted events rasulting in daath) Last Dua to (or es e consequence of): physician s tha buria Box 68760 Physician/Medical Due to (or as a consequence of): attending usa 0 P.O. Pert il. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? tha signed by the 1 Yes 2 No 3 Probably 4 Unknown Hyperlipemia, Coronary Artery Disease, Diabetes, Records, þ 24b. Were eutopsy findings eveileble prior to complation of cause of death? 24e. Wes en eutopsy performed? Completed peeu Peripheral Vascular Disease page 2 s certificata has 1 ☐ Yes 1 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home SPResidence 6 Othar (Specify) 2 1 Yes SE No 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of injury (Month, Dey Year) funaral 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Affer 1 Neturel 5 Pending I or Attending after death. Director: Aft 1 ☐ Yas 2 ☐ No invastigetion 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of injury - At home, farm, street, fectory, offica building, etc. (Specify) 3 4 Homicide 24 hours Furnital to the best of my knowledge, death occurred at tha time, date end place, and due to the ceuse(s) and menner es steted.

□ Medical Examiner: On the basis of exeminetion end/or invastigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stetad. 29a. Certifier Wedical (Check only one) 辨 29b. Signetura and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) N. Carles no D16189 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Suite# 223

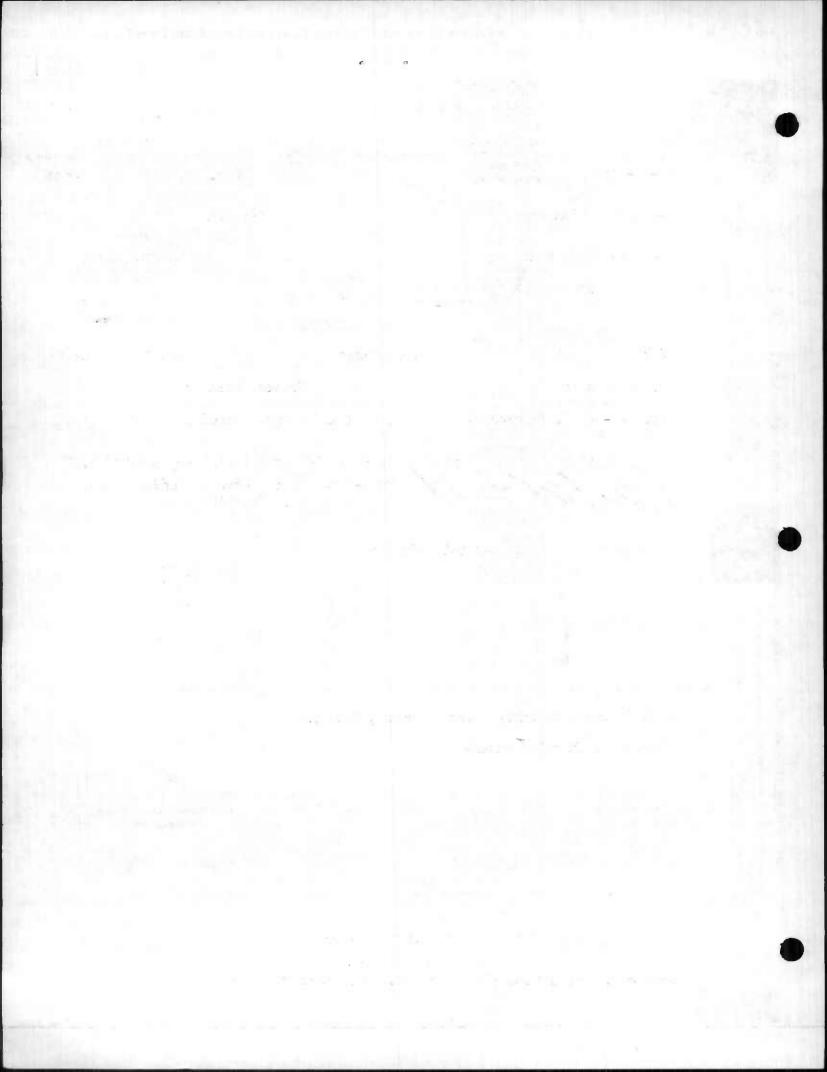
State Registrar 32. Registrer's Signature

George N. Karkar M.D. 1107 North Pt. Road Baltimore, MD

21224

31. Dete filed (Nepth, Pey, Year)

1 5 1997



State of Maryland / Department of Health and Mental Hygiene

30962 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** October Sarah C. DiGuardo 9:53 PM /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Lorien - Frankford Nursing Center Baltimore N/A If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 10M XDF Days 83 212-03-7145 Yes **Director** Massachusetts Usual Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inaide City Limits "natural", or items 23s or 28s-f show 1 X Yas 2 □ No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3715 Belair Road 21213 U.S.A. Funeral 72 hours efter death 12. Wes Decedant Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. Wes Dacedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White p 3 Nidowed 4 Divorced permit. Peges 1 and 2 should be filed within 72 ht Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "nature any injury or other traumatic avent, the Medical page. Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elementery/Secondary (0-12) Collega (1-4or 5+) Homemaker 8th grade Own Home 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surname) B Vincenza Palmisano Giuseppe Cottone 19e. Informant's Nama/Raiationship (Typa, Print) 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, State, Zip Code) Joseph DiGuardo 1701 Parkvue Road, Fallston, MD 20b. Ptace of Disposition (Nema of camatery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from State 4 Donation 5 Donation 5 Donation Fitombment Dulaney Valley Mausoleum 10/16/97 Timonium, Maryland 22. Name and Addrass of Fecility Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, Maryland shock, or heert feilura. List only ona causa on aach lina. 21236 Approximete interval Batween Onset and Death **Physician** /Medical immediata Causa (Final disaasa or condition Examiner Dua to (or as a consequence of) Examiner physician and the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disaese or injury that initieted avants rasulting in deeth) Last Dua to (or as a consequence of) Box 68760 Physician/Medical Due to (or es a consequence of): USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Wera autopsy findings availebla prior to completion of cause of daeth? should Completed 24a. Wes en eutopsy performed? has 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate on of Vital Physician: 25. Was case refarred to medical examinar? Be 26. Piaca of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding investigation 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of injury - At home, farm, straat, factory, office building, etc. (Specify) 4 - Homicide 1.2 Certifying Physician: To the best of my knowledga, daeth occurred at tha tima, date and place, and due to the cause(s) end menner as steted.
2. Medical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred at the tima, date and place, and dua to the causa(s) and manner stated. Medical 29a, Certifiar To the Within To the 29d. Dete signed (Month, Dey, Year) 29b. Signature and title g 29c. Licansa number ne and address of parson who completed cause of deeth (Item 23a) (Type, Print) KIVERA M.D. 5714 HARFORD 31. Dete filed (Month, Dey, Year) 32. Registrer's Signatura

State Registrar

Julia Savidson Randell

97-5802-033 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm SER State of Maryland / Department of Health and Mental Hygiene
Items: 23 part I,27 per MEO G-753 11/6/97 Certificate of Death
Reg. No. SAMANTHA AUBER 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth **Physiclan** OCTOBER 09, 1997 Samantha Amber /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner PRINCE GEORGES LAUREL REGIONAL HOSPITAL Laurel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys Hours 1 M 3 F 12 Yrs. July 7, 1985 **Director** 219-23-5090 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location r 28a-f show notified at Director MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 ž 20707 23a 15044 Cherrywood Drive USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Yes No If Yes, Give Yeer or Dates: 1 Never Merried 2 ☐ Married 1 ☐ Yes XX No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student Education 17. Fether's Neme (First, Middle Last) 18. Mother's Name (First, Middle, Meiden Surieme) Baltimore, Maryland Be Paul Dee Ellis, Jr. Susan Maria Humphrey 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Health J Paul & Susan Ellis/Parents 15044 Cherrywood Drive, Laurel, Maryland 20707 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Pages 1 X Burial 2 □ Cremetion 3 □ Removal from State B 8 4 ☐ Donetion 5 ☐ Other (Specify) Ivy Hill Cemetery 10/13 Laurel, Maryland 21. Signete of uneral Service Licensee 22. Name end Address of Fecility Fleck Funeral Home, Inc. anuel 7601 Sandy Spring Road, Laurel, Maryland 20707 of the mode of dying, such as cardiac or respiratory arrest. ir the disease, or complications that caused the death. Do not enter the mode of dying, eert feilure. Llat only one ceuse on each line. Physician /Medica Immediate Ceuse (Final disease or condition resulting in death)

98 use

Box 68760.

P.O.

Records.

Division of Vital or Attending Physician: Examiner Physician/Medical à Completed Be

Sequentially list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest

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MULTIPLE CONGENITAL ABNORMALITIES	
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Due to (or es e consequence of):	
No. alian Ani danah hasa ana malan da ahari da a	OOL Didd-base and the state of death

3 Time of Death

Birthplece (State or Foreign Country)

10d. Inside City Limits

Approximete Intervel Between

XXYes 2 No

Maryland

14. Rece - American Indian, Bleck, White, etc.

Specify: White

16:37 PM

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1XX Neturel 5'☐ Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number

OCME

State Registrar

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) A. KOPTU UP

111 Penn Street, Baltimore, Maryland 21201

OCTOBER 10, 1997

MARISMOS Dete filed (Month, Day, Year) 32. Registrer's Signeture whia Vavidson-Randalt 151997

hours efter death.

24 hours Hospital

To the Hosp within 24 ho To the Fune completely fi

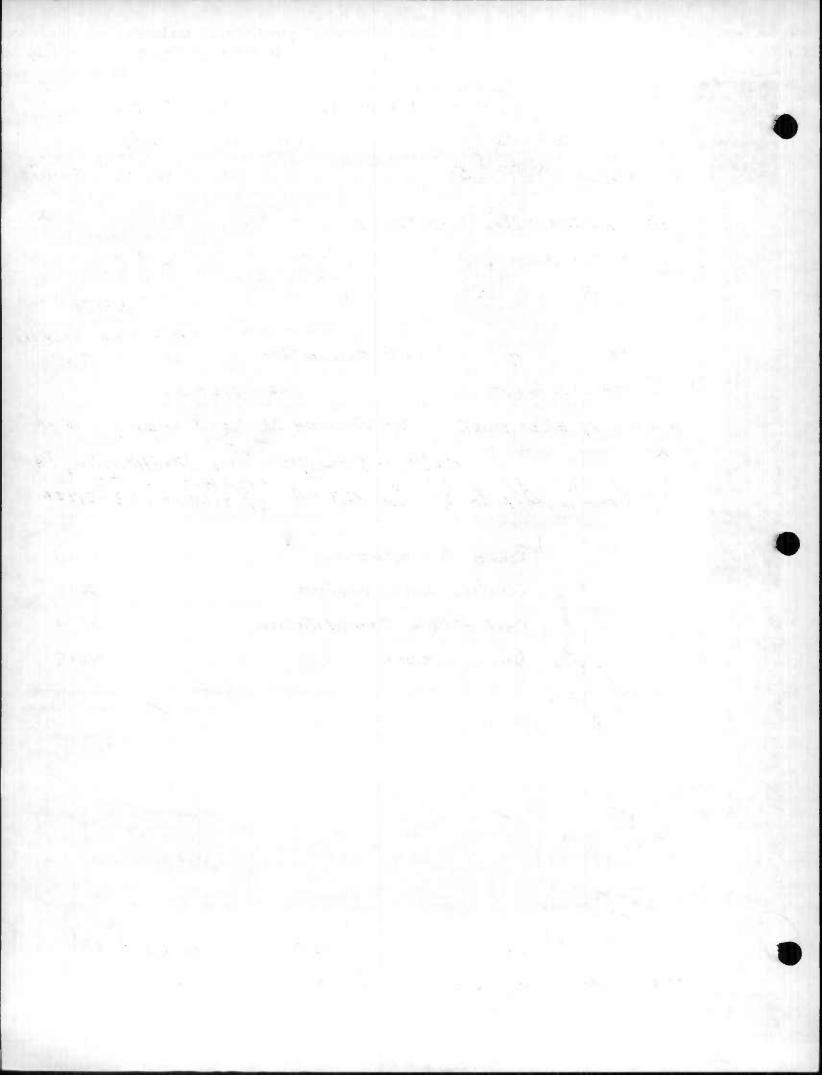
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Joseph EBERHAROT OCTOBER 7:03 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 8. Date of Birth (Month, Day, Year)

DEC 26,1946

ALLENTOWN If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 162-38-0957 Usual Residence of Decedent 50 Yrs. Director 10e. Stete 10b. County 10c. City, Town or Location r 28a-f show .notified at 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director NORTHAMPTON BETHLE HEM 10e. Street and Number 10g. Citizen of What Country? than "natural", or items 23s or the Medical Examiner must be r 5345 U.5.A TOWANDA DR 18017 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Maritel Stetus 14. Raca - American Indian, Black, White, etc. 1 and 2 should be filled within 72 hours after Health and Mental Hygiene. Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify: WHITE Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MUNICIPAL SELVICES Elementery/Secondary (0-12) College (1-4or 5+) CIVIL ENGINEER CONSTRUCTION 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be marked JOSEPH EBERHARDT HILDA MUSSEL 10 Pages 1 and 2. Settle for the 27 is m. v other tv 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETHLEHEM PA . 18017
Date 1 20c. Location - City or Town, State ANGELINEY EBELHARDI 5345 TOWANDA DR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Buriai 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Important: If it any injury or o Separtment NORTHAMPTON, PA 21. Signeture of Euperal Service Licensee , MD. ZIZZK 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) ISROIN STEM HERNIATION 1 year Examiner Due to (or es e consequence of): Examiner CEREBRAL FUNCAL INFECTION DAYS The law requires that the deeth certificate be executed bunel-transit Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) 180723 P.O. Box 68760. MARROW TRANSILANIATION Physician/Medical the Due to (or as a consequence of) 80 YEARS 1deviE LEUKEMIN for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 8 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy certificete hes 2 No 1 Yes 1 Yes 2 No or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1□Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1. Inpatient 2 ER/Outpetlent 3 DOA this funeral 27. Menner of Death 28a. Date of tnjury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Maturel death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide Pours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifies 29d. Dete signed (Month, Dey, Year) 1997 derezue 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) IVAN BORREUS IS DUTINORE N. WELFE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State relia Buideon-Randall OCT 151997 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 30965 Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death **Physician** LADY 12.10 AM 5 10 /Medical 4a. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore
If Undar 24 Hrs. 8. Date 7. Age (In yrs fast birthday) H Undar 1 Yaar 8. Data of Birth
(Month, Dey, Year)

November 17, 1907

Penns ylinna 8. Data of Birth (Month, Dey, Year) Months Deys 1□M 2 F Director the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notlined as 1 Yes 2 No Directo 10e. Streat and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Dacedent Evar in U,S. Armed Forces? Race - American Indian, Bleck, White, etc. 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: by 3 XWidowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Harse 17. Fathar's Name (First, Middla, Last) phen Grant 19e. Informent's Neme/Reletionship (Type, Print) Sher 3404 Parks
20b. Pleca of Disposition (Name of cametery, crematory or other piece) Prive, Baltimore 20a. Method of Disposition 20c. Location - City or Town, Stete OCTOBER 1 Burial 2 □ Cremetion 3 □ Removal from Stete 4 □ Donetlon 5 □ Othar (Specify) 21. Signetura of Funeral Service Licara 2121.
Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. 21217 Approximete Intervel Between Onset and Death **Physician** /Medical Immedieta Cause (Finel V disease or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if eny, laeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): P.O. Box 68760 Physician/Medicai Dua to (or as a consequenca of) Pert II. Other significent conditions contributing to deeth but not resulting in the undarlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? signed by i 3 □ Probably 4 □ Onknown 1 ☐ Yes 2 ☐ No Records, þ Completed 24a. Wes an autopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of death? this certificate 1 Yas 2FINO 1 ☐ Yas 2 ☐ No of Vital 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yes 2 No P 28e. Dete of Injury (Month, Day Year) 28c. injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: Helon 1 Naturel 5 Pending Invastigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and pleca, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, and due to the ceuse(s) end manner stated. 29a. Certifier Medicai To the Fune within 24 To the

State Registrar

29b. Signatura and title of certifier

31. Dete filed (Month, Dey, Year)

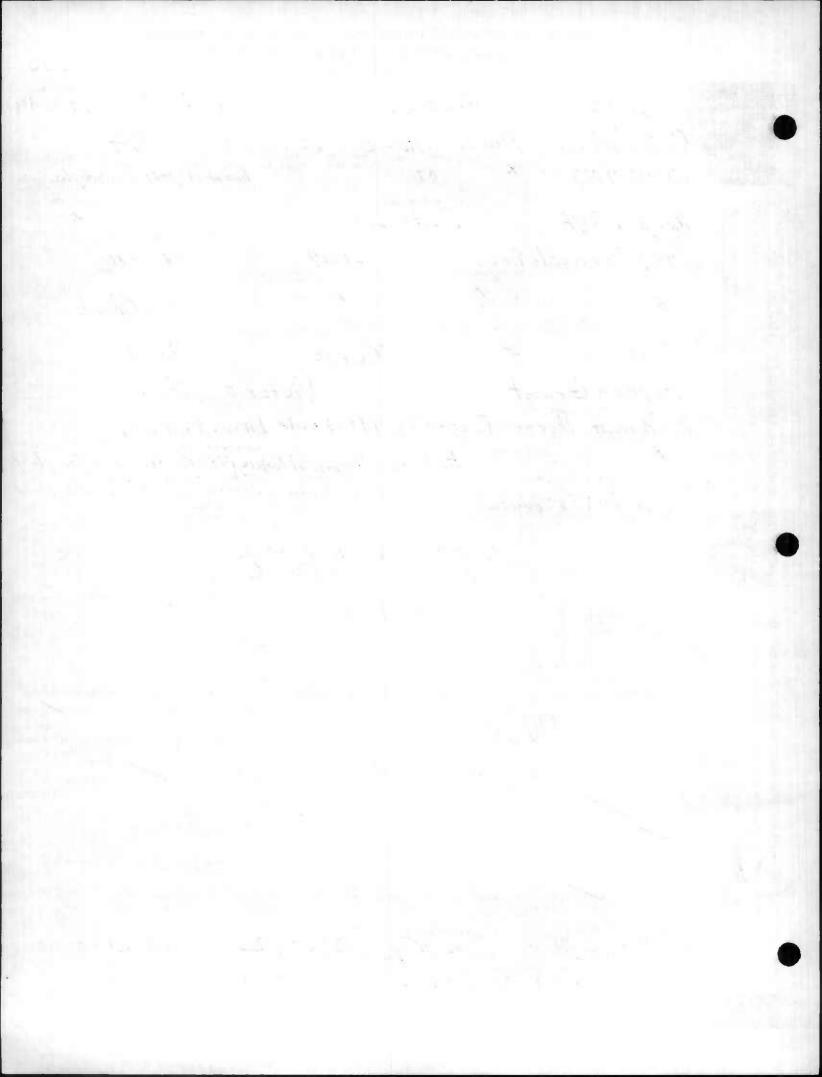
OCT 1 5 1997

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) B. TURAKHIA, MD. 1009, FRC FREDERICK RD. BALTIMORE, MO 1009, 32. Registrer's Signature

COVENI

29c. License number

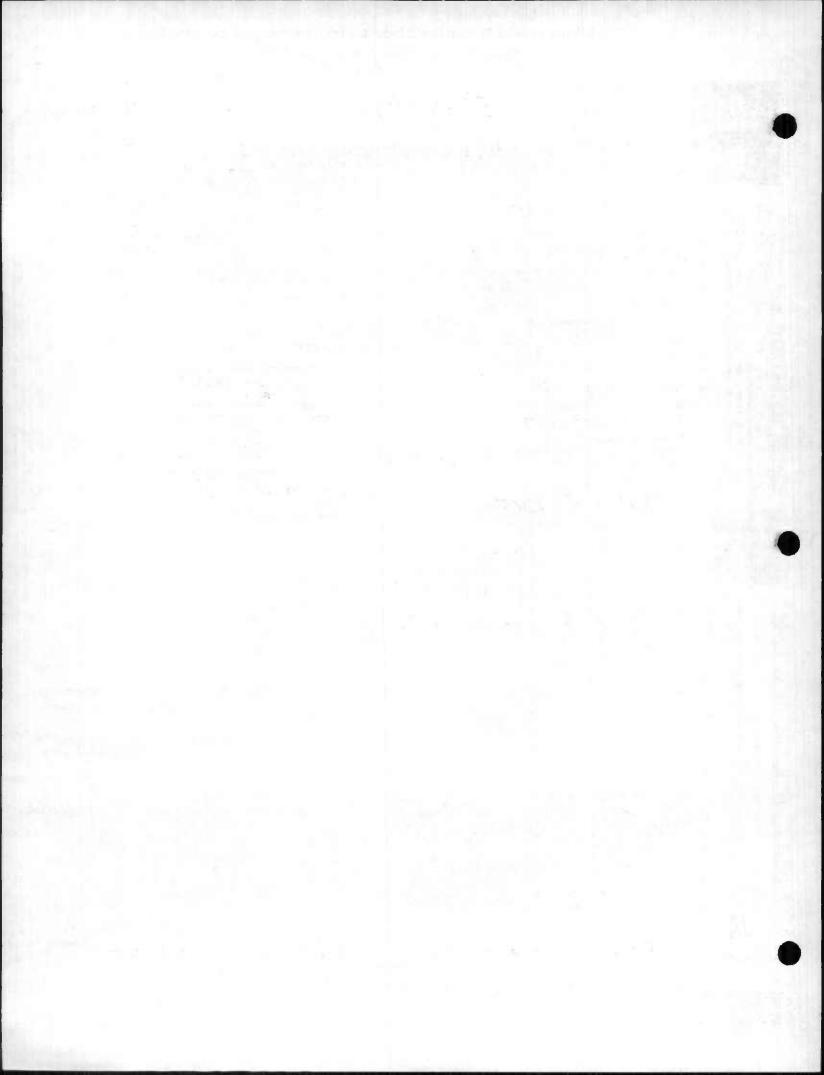
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State of Maryland / Department of Health and Mental Hygiene 9 7

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of show			Sex 7. Age (// 1□ M 1□ F 78	n yrs. lest bir	Yrs. If Und Month	der 1 Year If Under 24 s Deys Hours	8. Date of B (Month, D	irth 26,191	9. Birthplece (State or Fi
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It be not	Funeral Director	10e. Street end Number 1935 E. NORTH	AVE		10f. 2	Zip Code 21213		10g. Citizen of U . S	Whet Country?
P. Erm	2	11. Maritel Status  1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes ※ № No If Yes, Give Yeer or Dates:	or in U,S.	If Yes, sp	edent of Hispenic Origin pecify Cuben, Mexican, P 27 No Specify:	? (Specify Yes or N ruerto Ricen, etc.)	Ble	ce - Americen Indlen, ck, White, etc. by: BLACK
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Heelth ther tra		SHIRLEY MCLEAU	RIN	27:	21 E.	FEDERAL S	T BALTO	,MD 212	213
ant: If		20e. Method of Disposition  1 ☑ Burlel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special	Removei from Stete	cemeter	Disposition (A y, cremetory of ZION C	r other piece)	OCT 17	BALTO,	City or Town, Stete
Department important: If any injury o		21. Signeture of Funeral Service Lice	nsee ()		22. Name 1129	end Address of FecilityB	ETTS FU	NERAL F ALTO, MI	HOME 21213
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nding physician and use as the burlet-transit	Medical	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest	. metastah	c to	a Co consequence of unassociation of				ONKNOWA
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certificate rector, pag		00.111				-3-10-2	10	Yes 20 No	1 ☐ Yes 2 ☐ No
director,		25. Was cese referred to medical examiner?	Hospital:			Otto and	Deeth (Check only		Haca
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		4 ☐ Homicide determined	building, etc. (S	Specify)			City or To	wn, Stete)	per or Rural Route Number
Fund Fund Fund Fund Fund Fund Fund Fund	2000	29e. Certifier (Check only one)  12 Certifying Ph 2 Medical Exam	ysician: To the best of mainer: On the basis of exa end menner steted	amination end	, death occurre d/or investigation	d et the time, dete end p on, In my opinion, death o	lece, end due to the occurred et the time	ceuse(s) end me , dete end place,	enner es steted. end due to the ceuse(s)
JH 3		29b. Signature end title of certifier	1		2	9c. License number		29d. Date signe	d (Month, Dey, Year)
		* Katharine f	completed cause of deeth	UD.	Tupo Brich	035712		10/14/	97



State of Maryland / Department of Health and Mental Hygiene

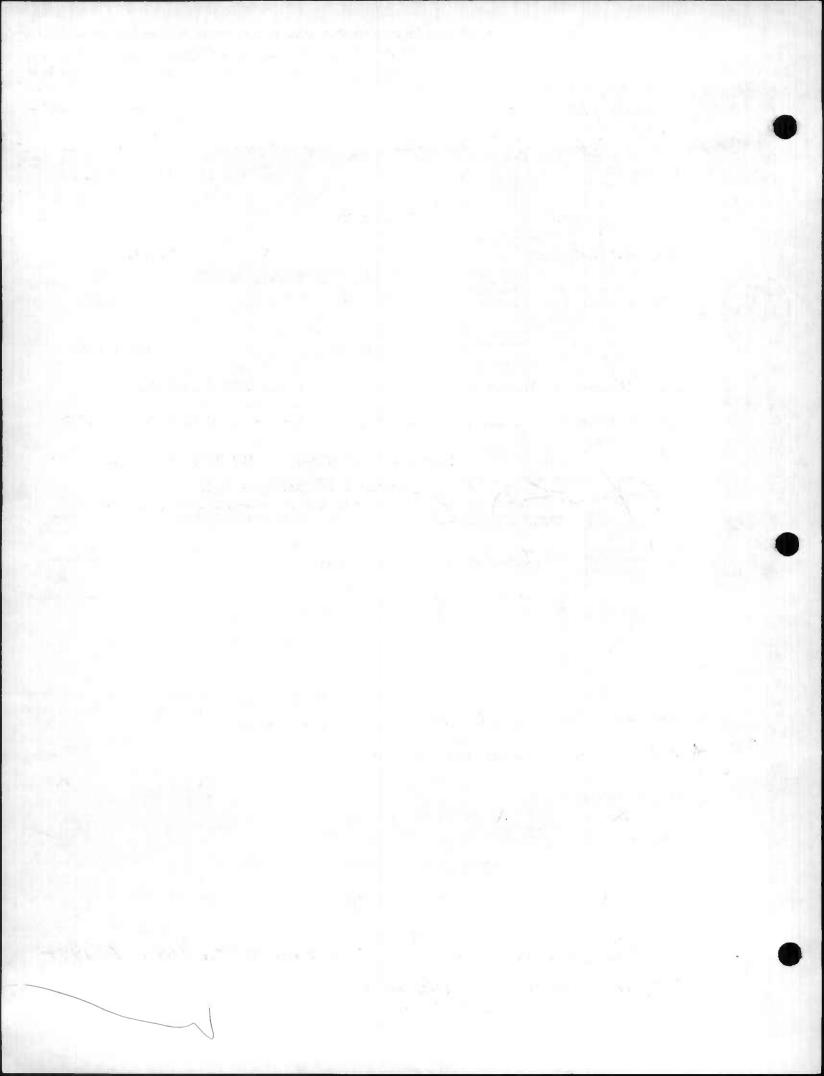
Certificate of Death

30967

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Physician /Medical		JULIA	M. FLE	MISTER	than				4b. City, Town, or I	2. Data of D Month OCTOL	Day	Yaar 1997 ity of Deet	3. Time of Death  3.15 PM
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any injury or other traumetic event, the Medical Examines must be nothed at once.  To Be Completed by Funeral Director		Marital Stetus 1 ☐ Navar Marr	onway Str	12. Was Deced	dent Ever in cas? 2 <b>X</b> No	U,S. 13		dant of	Hispanic Origin? (S ban, Mexican, Puert	pecify Yas or N o Rican, etc.)	lo- 14. Re		
sted by	-	3 Widowed	4 ☐ Divorced  15. Decedant's Edity only highast gra	Yeer or De	tes:	16e. Dec			ipation a during most of wor	rkina	16b. Kind of		
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To Be	3	John Her	(First, Middle, Lest, nry Harri	s						. Witze	1		
			eme/Ralationship ( SZAKİEWSK		nter)		_		e. Baltimo			n, Stata, 2	Zip Coda)
jury or our		4 Donetion	□ Cramation 3 □ 5 □ Othar (Specif	y)	toto	Place of Disp cematary, cri Oly Cr	oss C	other pl emet	cery	Data Oct.14 1997	20c. Location Brook1		Town, Stata
any in	21.	Signature of Fu	meral Sarvice Licer	1see	-		McCul. 130 E	nd Addr 1y-F	rass of Facility Polyniak l ort Ave.,	Funeral Baltim	Home o	f Sou . 212	th Balto.
ian ical iner	Imr	a. Pert1. Enter t shock, or hea mediata Ceusa aasa or conditic ulting in daath)	Final	e. De	men	tia (or as a cops	equance of)	: ,	ring, such es cerdiad		arrast,		Approximate financial Between Onsat and Death Chronic Chronic
uss as the bufal-transit	Serif a ceu Cartha tha	quentially list co ny, laading to in ise. Enter Unda use (Disaasa or i initieted avant ulting in deeth)	nditions, imadiata rhying Injury Sast	b. <i>Cert</i> c		ar le (or as a conse	aquance of)	:	enosis				Chronic
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leted by		ARter	atmy I	insoffice Ca	ardic	y DV 1980	vlar	di	sease	24a. Wa	Yes 2 No	24b.	Were eutopsy findings available prior to completion of ceuse of death?
Comp										1	Yas 20 No		1 ☐ Yes 2 No
ni director, page 2 : To Be Comp		Was cesa rafer axaminar?  1 Yas 2	No			☐ ER/Outpatio	1	OA		loma 5□Ras	sidance 6 🗆 O		cify)
ed in by the funer Certification:		Manner of Deat  Natural  Accident  Suicida  Homicide	5 Pending Invastigation 6 Could not be determined	28a. Place o		28b. Tima Injury	М	1[	ury et ork? ☐ Yes 2 ☐ No	28f. Location	Streat and Nur		ural Routa Number,
completely filled in	298	a. Cartifier (Check only one)	1⊠ Certifying Ph 2□ Madical Exam	yalcfan: To tha b	est of my kn	lowledge, dae	oth occurred	l at tha t	time, dete end place opinion, daath occu	, end due to the	e ceusa(s) and r	mennar as	stated. to the cause(s)
W W	29b	SOL	titia of certifiar	nME	>		7	C. Licar	1664		29d. Deta sign	ned (Mont	h, Dey, Year)
12)		C.E.	JENSE	complated cause	of death (Ita	am 23a) (Tyge	Print)	DE	1664 enton	MD a	21629	7	
State egistrar	31.	Data filed (Mon	th, Day, Year) 5 1997	Julia Pulia	gistrer's Sign	natura - Randa	2						

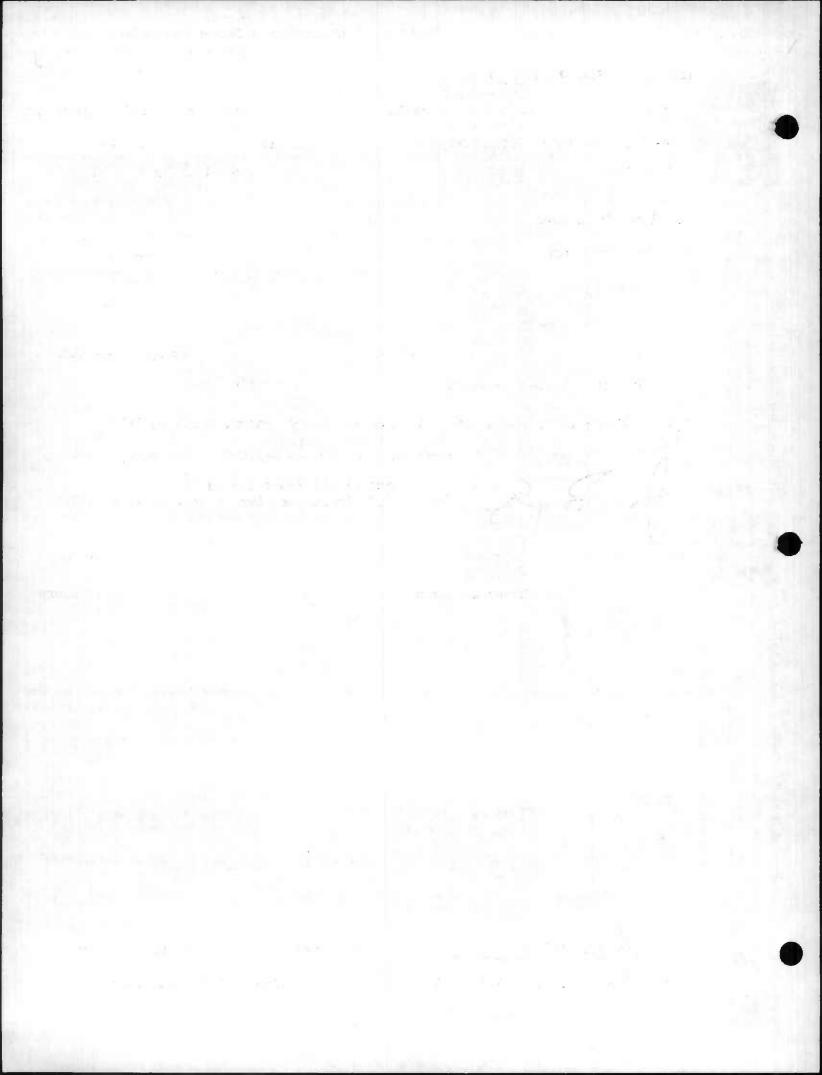
Dementies
Cercenculiences lenesses

		1. Decedents No	ma /Finak kkidalla	f and		Certificat	e of	Death		Reg. No.	<i>}  </i>	30968
Physicia	an	7	me (First, Middle,						2. Date of D	Day	Year	3. Time of Death
/Medic		Doro	Ly V. F	ischer					Octobe.	100 11	997	2:45 P
Examin		4e. Facility Name	(If not institution,	give street end numbe	er)			4b. City, Town, or I	Location of Dear	th 4c. County	of Death	
		Sinai	Hospit	41 of Ba	eltimore			Balting 14 Hrs	2000	To	Him	0-0
Funerai		5. Sociel Security		Sex 0 7.	Age (In yrs. last bir	hday) If Under		II OHOO ETTIO.	_ o. Date of bi	rth	9. Birtho	lace (Stete or Foreign
Director		219-12-6	781	1□M 2€ F	74	Yrs. Months	Deys	Hours Min.	FEB 17	.1923	MAR	YLAND
D		Usual Residence	of Decedent							,		
how h		10a. State	10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
eath with the Maryla w 23e or 28e-f show must be notified at	Director	MD	HOWARI	D	ELL:	COTT CI	TY					1 ☐ Yes 2 No
4 8 8	je je	10e. Street end N	umber			10f. Zip	Code			10g. Citizen of	What Cour	itry?
A Sa o		3075 ST	. JOHNS	LANE				21042		U.S.A	A.	
1 2 2	Funeral	11. Marital Status		12. Was Deceder	nt Ever in U.S.	13. Was Deced	lent of H	lispanic Orlgin? (S	necify Yes or N	o- 14. Rac	ca - Americ	an Indien
2.26	5		rried 2 Marrie	Armed Force	\$?	If Yes, spec	ify Cub	lispanic Orlgin? (S en, Mexican, Puert	o Rican, etc.)	Bla	ck, White,	
E LL	by		4 Divorcad	If Yes, Give Year or Detes		1 Tes	<b>2</b> □ No Specify:			Specif	y: WH	ITE
	P	0 3 11101100				Decedentia Have	100000	atta-		405 Kind of D		
	Completed	(Spi	15. Decedent's ecify only highest	grede completed)	108.	(Give kind of wor	rk done	pation 16b. Kind of Business/Industry during most of working (d)				
1 1 1	E	Elementery/Sec 12TH GR		College (1-4o	or 5+)	HOMEM				Н	OMEMAI	KING
Hyg Hyg ither			First, Middle, La	enet					- (Fine Adidate			
od od	Be			IO VALDIVI	A			18. Mother's Nan				
marked other	2				A			CLARA	LOUISE	ARMSTRO	NG .	
0 0 2			nant's Name/Relationship (Type, Print)  TANCE WARREN (DAUGHTER)  19b. Mailing Address (Street and Number or Run 3075 ST. JOHNS LANE —									
other tr		CONSTAN	CE WARRE	N (DAUGHTE	R) 30	)/5 ST.	JOHN	NS LANE -	ELLICO	TT CITY	, MD	21042
		20a. Method of Di		Ta		Disposition (Nen y, cremetory or o	ne of ther ple	ca)	Dete	20c. Location	City or To	wn, State
nent of H			5 ☐ Other (Spe	Removal from State	10	PARK C			10/13/9	7 BALT	IMORE	
		21. Signatu	ungal Service Lic	ensee /	-1	22. Name an	d Addre			1		
permit. Departrimports any inju		NY	Varia -	1	1.8-			JNERAL HO	ME INC.			
		1 4	eus c	- 4	T			ENS AVENU			) 2	1229
		23a, Pert1, Enter shock, or he	the disease, or co art feilure. List or	emplications thet causely one cause on each	ed the death. Do r	ot enter the mod	e of dyir	ng, such es cardiac	or respiratory	errest,	i	Approximate Intervel Between
hysician				0								Onset end Deeth
/Medical		Immediate Cause disease or condit	on	· Cant	Pal S.	207:10	27 . 70	,			1	2mos
xaminer	.	resulting in death		0.	Ral S	onsequenca of):					1	
*	Examiner			D. Isch	e mair	(.1.	1.7				1	3, -
rans	E	Sequentially list of	onditions	b	Due to (or as a d	onsequenca of):	10					2415.
an ei	M	Sequentially list of any, leading to cause. Enter Unc Cause (Disease of	mmediate leriving			,						
physician end s the bunal-transit	edicai	that initiated even	IS The state of th	C	Due to (or es a c	on sequence of):		_				
	g	resulting in death	Last		Due 10 (0) es a c	onsequenca or).						
use e	3			d								
attending for use e	Car											
ed by the detached	Physician/M			contributing to death						tobacco use co	ntribute to	the cause of death?
		Grast	ic (11.	con (1	OPD	brown	4.	064444	1 🗆	Yes 2 No	3 Prot	bably 4 Unknow
te has been signed by the attending physician end page 2 should be detached for use as the bunal-transit	by		10 11	-	1	MICHE	wo f	ZIXIMIN	14		1	
been si	Completed by	44.0.	colo 1	z cardio	0.000- 1	1.			24a. Was	s en autopsy ormed?	ava	ere autopsy findings allable prior to
S S S	ple	TIMERO	xierot	- cardio	ruscul	er dise	use				of	mpletion of cause deeth?
page 2	EO								1.00	Yes 2□No	1 [	Yes 2 No
60 -		25. Was case refe	rred to medical					26 Plans of D				- 100 M/110
certific lirector,	o Be	examiner?		Hospital:	Nines of the co		Oth	26. Place of Dea				
	٠ <u>۲</u>	1 ☐ Yes 2) 27. Manner of Dea	No	1 Inpa			'A	4 LI Nursing H		idenca 6 Ott		0
Affar funer	Certification:	1 Natural	5 Pending	28a. Date of In (Month, E			8c. Injur Wor		ZOU. DUSCIDO	how injury occur	190	
ector: / by the f	cat	2 Accident	investigat			М	1 🗆	Yes 2 □ No				
after deeth.  Director: A  I in by the fu	=	3 ☐ Suicide 4 ☐ Homicide	determine	208. Place of I	njury - At home, far etc. (Specify)	m, street, factory	, office			(Street end Numi wn, Stete)	per or Rura	I Route Number,
ed ir	Ce				,							
within 24 hours To the Funaral		29a. Certifier	1A Certifying	Physician: To the bes	st of my knowledge	death occurred a	at the tir	ne, dete end plece	, end due to the	ceuse(s) and ma	anner as si	lated.
within 24 hours after To the Funaral Dire completely filled in b	edical	(Check only one)	2☐ Medical Ex	aminer: On the basis and manner:	or examination and stated.	vor investigation,	in my o	pinion, deeth occu	rred at the time,	, date and place,	and due to	the cause(s)
To the	ž	29b. Signature an	title of certifier			290	. Licens	e number	T	29d. Dete signe	d (Month,	Dey, Year)
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State of Maryland / Department of Health and Mental Hygiene Q7 30050

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sician		me (First, Middle, Las							2. Dete of Month	D	өу	Yeer	3. Time of Deeth
edical	Agnes		oyce		GREEAF	}		4b. City, Town, o	Octo		3.19	-	3:00 P.M
ıminer		(If not institution, give n Square 1			_						c. County		
al	5. Sociel Security	Number 6. Se	9x 7. A		last birthday)	If Unde	er 1 Year		S. 9 Date of	Ridh		imore 9. Birthples	ce (State or Foreig
or	213 36 59 Usuel Rasidence		□ M 2 XX	5	8 Yrs.	Months	Deys	Hours Mir	June	12,19	39	Mary.	ce (State or Foreign Land
	10e. Stete	10b. County		10c. Cit	y, Town or Lo	ocation						100	I. Inalde City Limits
to	Maryland	Baltimor	re		Es	sex							1 ☐ Yes 2 📉 No
Funeral Director	10e. Street end No.	umber Mark Court				10f. Zi	ip Code 212	221		10g. C	itizen of V	What Country	n
þ	3 ☐ Widowed	ried 2 Merried 4 Divorced	12. Was Decedent Armed Forces 1 Yes 27 If Yes, Give Yeer or Detes:	? No	1	Was Dece If Yes, spe 1 Yes		lispenic Origin? ( an, Mexican, Pue Specify:	Specify Yes or rto Rican, etc.)	No-		e - American ck, While, etc	c.
Completed	(Spe	15. Decedent's Ed acify only highest grad condery (0-12)		5+)		kind of wi DO NOT u	uel Occup ork done use retired	etion during most of we d)	orking			usiness/indu	
		(First, Middle, Last)			Cash	ıer		10 Notes de N					Store
Be Completed by Funeral Director	Oh-		iam Sch	ıldt.				18. Mother's Ne		Warcl		10)	
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TO		Greear, Jr		(br				Court E					000)
once.	20e. Mathod of Di	sposition		20b. P	lose of Dieno	eition /Na	me of	ce) 10/16	Dete			City or Towr	n, Stete
	4 Donetion	□ Cremetlon 3 □ 5 □ Othar (Specify	)	Wo	odlawn	Ceme	etery	7 10/06	1		timor	re, Ma	ryland
ouce	21. Striature of F	uneral Sarvice Licens	2	1				s of Equility Lastern			Mary	land	21221
	23a. Part Enter	the diseese, or comp ert feilura. List only o	lightions that cause	d the death								A	pproximete ntervel Between
n	V		1										Inset end Deeth
al er	Immediate Ceuse diseese or conditi	on	Sepsis									6	0 Hours
	resulting in death)			Due to (o	r es e consec	quenca of)	):					1	
- in			bBronch	opneu	monia							7	2 Hours
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2	resulting in deeth) Lest  Due to (or es e consequence of):												
3			d										
by Physicia	Pert II. Other sign	ificant conditions co	ntributing to death I	out not resu	ulting in the u	nderlying	ceuse aiv	en in Pert I.	23b. 0	old tobacc	o use co	ntribute to ti	he cause of death?
y Physician/Medical			•							□ Yss			bly 4 Unknow
Completed by										les en eute erformed?	opsy	availa	e eutopsy findings able prior to oletion of cause
dwo													
e Com	25. Wes casa rafe	rred to medical					_	26. Place of De		Yas 2	ZLINO	185	Yas 2□ No
To Be	exeminer?		Hospital:	ient 2 🗆	ER/Outpetier	nt ~3□ D	OA Oth	ar	Home 5□R	-	6 □Oth	er (Snecify)	
	27. Menner of Dea	th	28a. Data of Inj (Month, Da		28b. Tima of		28c. Injur Wor		28d. Descri				
atio	1 □ Natural 2 □ Accident	5 Panding Investigation	(Month, De	ay rear)	Injury	М		Yes 2□No					
Certification:	3 ☐ Sulcide 4 ☐ Homicida	6 Could not be determined	200. Pleca of in	jury - At ho tc. (Specif)	me, ferm, str	eet, factor	ry, office		28f. Location City or	n (Street a Town, Sta	and Numb ta)	er or Rural F	Route Number,
edical Ce	29e. Certifier (Check only one)	1 Certifying Phy 2 Medical Exami	alcian: To the best iner: On the basis of end menner s	of axaminat	wledge, deeth ion and/or inv	occurred vestigation	d et the tin n, In my o	ne, date and place pinlon, deeth occ	e, end dua to	tha causa( ne, date er	s) and ma	innar as stat and dua to th	ed. na cause(s)
Me	29b. Signature and	title of pertiller				29	c. Licens	e number		29d. D	ate signe	d (Month, Da	ay, Year)
	> A	i. Apolo	5	$\geq$ .		I	R D 1	1926		Octo	ober	13, 1	997
	The second secon			death /Itam	00a) /T.aa	Daint							
	Dr. Sh	eena Anton					-	Baltim			4 0 0		

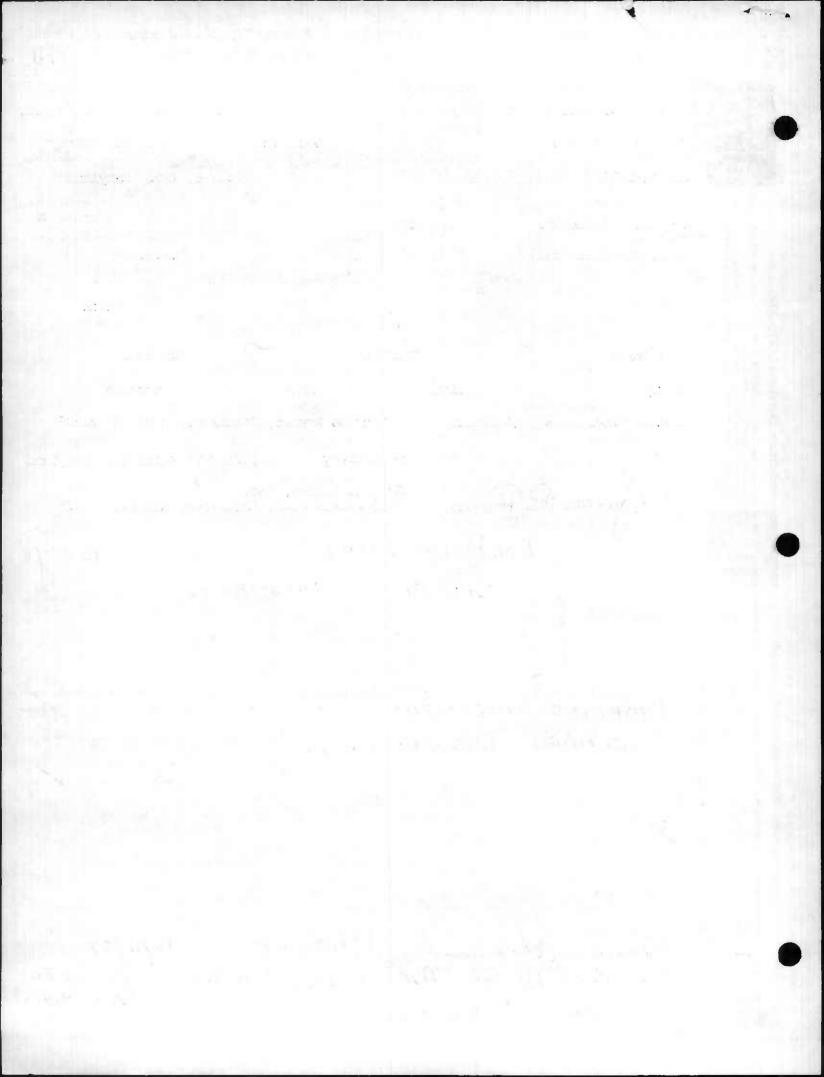


State of Maryland / Department of Health and Mental Hygiene 97

					Ce	rtificate (	of L	Death		R	eg. No.		
5,		1. Decedent's Neme (First, Middle, L	ast)							2. Dete of Deet	h	Vecs	3. Time of Death
Physici /Modic		Catherine Amelia	a Gist							Month October	10 1	Year 997	3:10 A.M.
/Medic Examin		4e. Fecility Neme (If not institution, g		umber)		1 12 H	41	b. Clty, Tov	wn, or Lo	ocation of Deeth	4c. Count		J.IO A.M.
EXAMINI	iei	Augsburg Luthera						ochea			1		County
			Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Y	1	If Under		8 Date of Birth			
uneral irector		212-01-9577 Usuei Residenca of Dacadant	1□M 2XIF	89	Yrs.		eys	Hours	Min.	8. Dete of Birth (Month, Day, Oct. 6,			elece (State or Foreign etry) Land
A 12		10e. Stete 10b. County		10c. City	, Town or Lo	ocation						1	0d. Inside City Limits
paigno	Director	Maryland Baltimo	re	Loc	hearn	1017:0							1 ☐ Yes 2 No
el', or items 23a or 28a-f ehow Examiner must be notified at		6811 Campfield R	oad			10f. Zip Coo 2120				1	0g. Citizen of U.S.A.		Hry?
CHEST	Funeral	11. Meritel Stetus  1 Never Merried 2 Married	Armed F 1 ☐ Yes	2KI No		Was Decedent If Yes, specify ( 1 ☐ Yes 2 🔀	Cuber	spenic Orlo n, Mexican Specify:	gin? (Spo , Puerto	ecify Yes or No- Rican, etc.)	Ble	ce - Americ ick, White,	
Era	by	3 ₩ Widowed 4 □ Divorced	If Yes, G Yeer or I			THE ZEN	NO	Specify:			Specia	Whi	te
the Medical Ex	Completed	15. Decedent's I (Specify only highest g	Education rade completed,	)	(Give	dent's Usuel Oc kind of work do DO NOT use re	one d	lurina most	of work	ing	16b. Kind of E	lusinass/în	dustry
The	omb	7th Grade	Coilege	(1-4or 5+)	Homen		imea				Own Ho	ome	
vent,	Bec	17. Fether's Neme (First, Middle, Las	it)					18. Mothe	r's Neme	e (First, Middle, A	Aeidan Sumei	me)	
9 6	To B	Henry		Kride	r			Anna			Kru	elle	
		19e. Informent's Neme/Raletionship	(Type, Print)	10		ng Address (St	reet e	nd Numbe	er or Run	el Route Number	City or Town	, Stete, Zip	Code)
other traumatic		Brenda Virginia	Majka/Da	aughter						altimore			
any injury or other tr once.		20e. Mathod of Disposition  1   Buriei 2 □ Cremetion 3  4 □ Donetion 5 □ Other (Special Contents)		State	emetery, crei	osition (Neme of metory or other Cemete:	place	в)	1	Dete :	20c. Location		wn, Stete Maryland
Injur.		21. Signeture a Funeral Service Lice	•	1.41		2. Name end Ad		s of Fecilit		0/13/9/	Darti	TIDIE	ratyland
any l		Δ	00	}		ohn C. I							
		Juanita	M 74	omas.	64	115 Bela	air	Road	d, B	altimore	Mary	land	21206
		23a. Pert1. Enter the diseesa, or con shock, or the at failure. List ont	npilcetions thet	caused the deeth eech line.	. Do not ent	ter the mode of	dying	g, such es	cardiec (	or respiretory erre	est,		Approximata Interval Between
ician		O.							,				Onset end Deeth
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T.	Ine			CERE	BRA	7c	1	IHR	DM	BUSIS		1	U
1	Examiner	Sequentially list conditions,	D	Dua to (or	es e consec	quenca of):						1	
1		if eny, laeding to immediate cause. Enter Underlying Ceusa (Disaese or Injury										i i	
the b	edical	thet initiated avants resulting In daath) Lest	C	Due to (or	as a conseq	juence of):		_					
for use as the burial-transit	Mec											į	
5	lan		U									i	
detached for use	Physician	Pert Il-Other significant conditions	_	leath but not resu	Iting in the u	nderlying cause	a give	n In Pert I.		23b. Dld to	bacco use co	ontributa to	the cause of death?
se detac	by Ph	DIABETES	· /	Dusu	TUS					1 🗆 Y	es 2□ No	3 Prol	bably 4 Unknown
should be det		( DRONAL	2e/	DNSU	FFIC	LENC	so			24e. Was a perform		ev	ere eutopsy findings eilable prior to
N	ple		-				_{_						mpletion of cause daath?
director, page	Completed									1 □ Ye	s 10 No	10	Yes 20 No
	Bec	25. Wes case referred to medical						26 Place	OMPast	h (Check only on			
	To B	examiner? 1 ☐ Yes 3 ☑ No	Hospitai:	Inpatient 2 1	ER/Outpetier	nt 3 DOA	Othe	r. /		me 5 Reside		her /Sneal	(v)
		27. Manufer of Deeth	28e. Date	of Injury	28b. Time of	f 28c. I	njury	et		28d. Describe ho			7/
Tunerai	tio	Neturel 5 Pending Investigation	(Mor	nth, Dey Year)	Injury		Work	:? /es 2 □ !			, ,		
oy the	fica	3 Sulcide 6 Could not	be on Di-	a of Injury - At ho	me ferm str					28f. Location (St	reet end Num	ber or Rura	il Routa Number.
:	Certification:	4 ☐ Homicida datarmine	build	ling, atc. (Spacify	)	231, 130101y, Oli	.00			City or Towr	, Stata)		7,011,001,
diy me	edlcal C	29a. Certifier (Check only 2 Medical Exa	hysician: To the	a best of my know	vledga, daatl	h occurrad et th	e tim	e, date end	d plece,	end due to the ce	ouse(s) end m	annar as s	tated.
completaly filled in		one)	end mer	nnar statad.	on enworth				ar occurr				
600	Σ	29b. Signeture and title of certifier	1			29c. Llo	ense	number		2	9d. Dete sign	ed (Month,	Day, Year)
		Lasnem	Hal	ehan	٥.	L	2	185 E	75		101	11/9	7
		30. Name end eddrass person who	completed cau	se of death (Item	23a) (Type,	Print)			0.0		/	1-	424
		7220 YARK	HEIC	गर्भा रहिता	4VE	121	7	10	IN	1) 212	08./	TA	SNEEM
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State Registrar 31. Dete filed (Month, Dey, Year)

OCT 1 5 1997



State of Maryland / Department of Health and Mental Hygiene 30971 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Erika D. Heidel October 0 14, 1997 5:30 a.m. /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 4801 Edgar Terrace Baltimore City 7. Age (In yrs. last birthdey) | If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Months | Devs | Hours | Min. (Month, Dey, Year) 5. Sociel Security Number Birthplece (Stete or Foreign Country) **Funeral** Deys 1 M 2 X F Yrs. 213-36-7547 75 Director Feb. 10, 1922 Germany Usuel Residence of Decedent 10e. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla Department of Heelih end Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other treumatic event, tre Medical Examples must be notified a once. 1 X Yes 2 No Director Baltimore City N/A Md. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4801 Edgar Terrace 21214 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify. þ 3 X Widowed 4 □ Divorced White Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elisabeth Blumenauer Joseph Myers 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Baltimore, Maryland 21214 Andrew Heidel (Son) 4801 Edgar Terrace Baltimore. 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from Stete Gardens of Faith 10/17/97 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee Milton Knight Jr 22. Name end Address of Fecility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician Immediate Cause (Final disease or condition resulting In deeth) /Medicai INVASIVE ADENOCARCINOMA OF 1- ZYRS COLON Examiner Examiner Baracitic Noded METASTASIS 10 attending physician end for use as the bunal-transit certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In deeth) Lest Due to (or es e consequenca of): LIVER Box 68760. METASTASI 20 Physician/Medical Due to (or es e consequence of): use as t OBSTRUCTION CARCINOMATISMS ABDOMINAL P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings evalleble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed certificate has 1 Yes 2 No 1 Tyes 2 No Division of Vital 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 1 ☐ Yes 25 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28b. Time of al or Attending Planta daath.

I Director: After the in by the funera 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital hin 24 hours 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier Do 3577 10/14/97 L. de Keen mD 30. Name and eddies of person who completed cause of deeth (Item 23e) (Type, Print) 98 N. Benavay Balto. Md: 21231 AUGUSTO

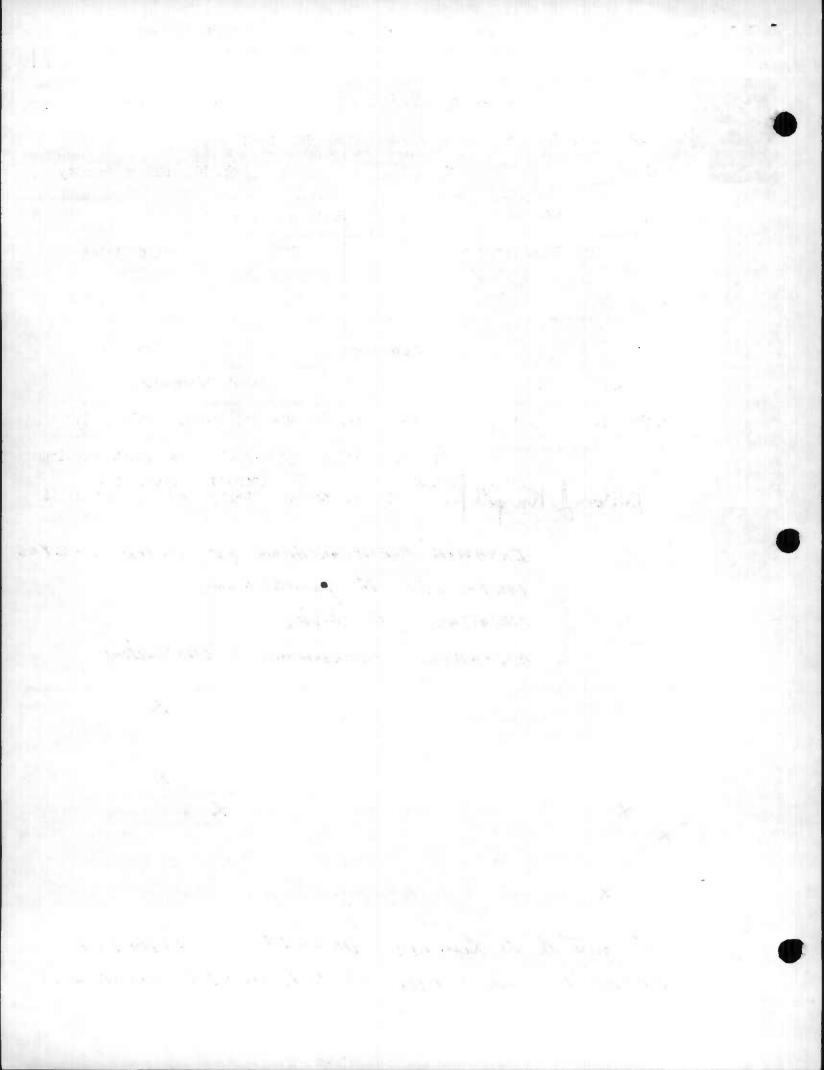
State Registrar 31. Date filed (Month, Day, Year)

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Registrar's Signeture

OF Junio Suridson-Randalle



10g. Citizan of What Country? U.S.A P.O. 50×501 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 22 No If Yas, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritai Status 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 No 3 Widowed 4 □ Divorced BLACK

15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Coilege (1-4or 5+) fOMEMAKEL 12 DWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama)

GEORGE JENNIE STUDIBANT

19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) ETHEL DR #202 LAUREL, MD - 20724
vata 20c. Location - City or Town, Stata ANNA 176

20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 1 Buriai 2 Cramation 3 Removal from Stata 4 Donation 5 Othar (Specify) RESTLAWN MAUSOLEUM

21. Signature of Funeral Service Licenses

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Metastatic Immediata Causa (Finai Colon Cancer disaasa or condition rasulting in daath)

Sequantially list conditions, if sny, laading to Immadiata ceusa. Entar Undarlying Causa (Diseesa or Injury that influed events rasulting In daath) Lest Dua to (or as a consequence of)

Dua to (or as a consequance of):

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 25 No 3 ☐ Probably 4 ☐ Unknown

24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yas 2 No 1 ☐ Yas 2 ☐ No

25. Was casa rafarred to medicel axaminar? 26. Placa of Death (Check only ona) STELLA MARIS AT MERCY 1 ☐ Yas 2 No Othar: 4 Nursing Homa 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 5 ☐ Rasidance 6 ☐ Othar (Specify) HOSPICE 27. Menner of Death 28b. Tima of

28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how Injury occurred 5 Pending Invastigation 1 Naturel 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida

Medical Certification: 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifian

29b. Signatura and titia of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year)

D. Damo ms 040480

30. Nama and eddress of person who complated ceusa of death (Item 23a) (Type, Print) Belair 5810 FERNANDO FERRO, MD Balto

31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State Tulia Tavidson Rendelle OCT 15 1997 Registrar

**DHMH 16 Rev 6/95** 

RUTH HARRINGTON

Baltimore, Maryland 21215-0020

Hygiene.

Pages 1 and 2 should be Haalth and Mantal

If Item 27 is marked other than

**Physician** /Medical

Examiner

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or Attending Physician: The law requires that the death certificate be executed

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After

Director: A

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P.O. Box 68760.

Division of Vital Records,

Examiner

Physician/Medical

Completed by page 2 should be

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Completed

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2. Data of Death

4c. County of Death

October

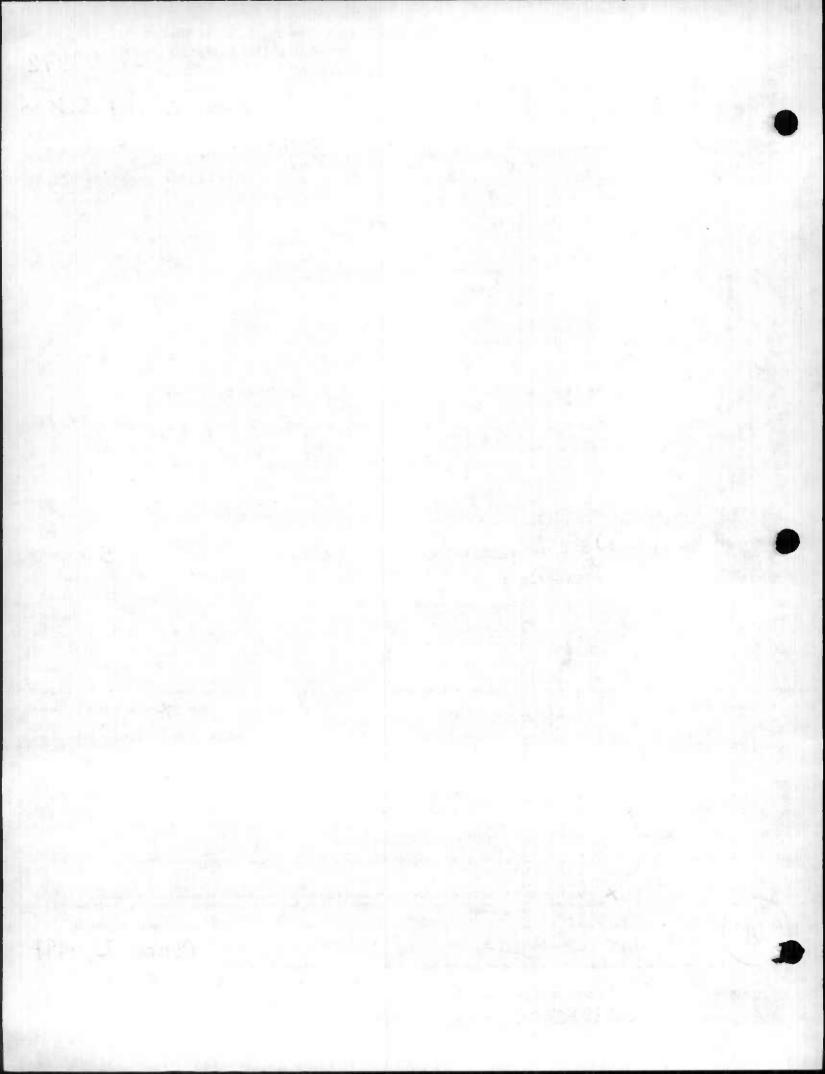
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5:30 am

9. Birthplaca (Stata or Foreign Country)
WADESBORD D. C.

10d. Insida City Limits

Vas 2□No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month SIL Vaar Physician MANY HAYNES OCI 17=45 H /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ER HARFORS HAVNEDF GLACE HOSPITAL MEMORME 8. Date of Birth (Month, Day, Year) Apr. 30, 1944 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 9. Birthplaca (Stete or Foreign Sex 1□ M 20 F **Funeral** 447-42-2414 Usual Rasidence of Decedent Yrs Director TULSA, OK the Marylend 10a. State 10b. County, 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow traumetic avent, the Medical Examiner must be notified at 1 Yes 2 No Directo ABERDEEN 10e. Street and Number 10g. Citizen of What Country? 238 0.5.A 100 21001 Funeral should be filed within 72 hours efter death . Was Decedent Ever In U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Dacedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0020 0 1□ Yes 2 No g Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Spacify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 UNITRESS HOTEL 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be is marked of EVA MAE FORD 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 end 2 s ment of Heelth en permit. Pages 1 end 2: Department of Heelth el Important: If item 27 is any injury or other traconce. ABERDEW, MD . 2 Date ... | 20c. Location - City or Town, State WILLIAM NELSON HAYNES Baltimore, 20b. Place of Disposition (Neme of cemetary, cremetory or other plece) OCT. 13 20a. Method of Disposition 1 Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) BACTIMORE 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Com wany disease or condition resulting in death) ANTENY DISEASE Examiner Due to (or as a consequence of): Examiner Ascumo cian: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) and Box 68760. ettending physician for use es the burie Physician/Medical Due to (or as a consequence of): signed by the ettending d be deteched for use Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown HYPERTONSION Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? 1 Yes 2 No 1 Yas 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of Injury 27. Manner of Death 28d. Dascribe how Injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Dev Year) Natural 5 Pending 1 Yes 2 No Invastigation MA 2 Accident NA NA 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide MA 24 hours Furneral 29a. Certifier Medical 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hose within 24 he To the Furns completely I (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifie BMG OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Dey, Year)

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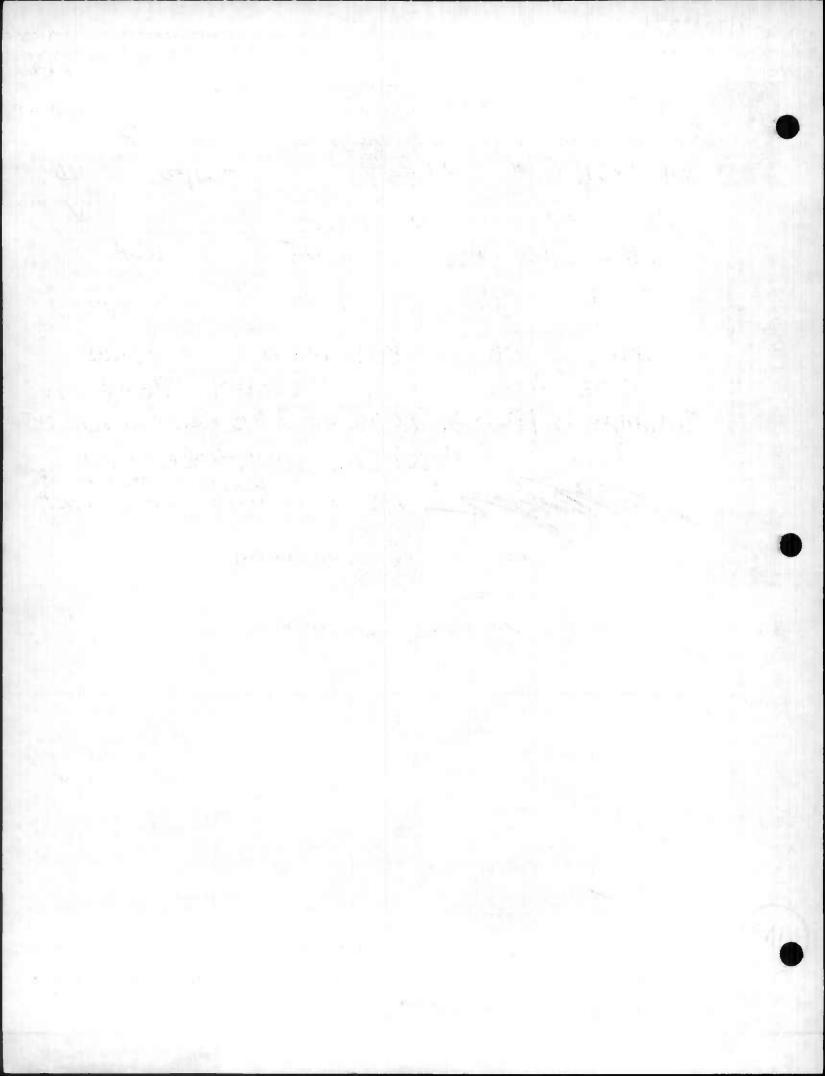
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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene q 7

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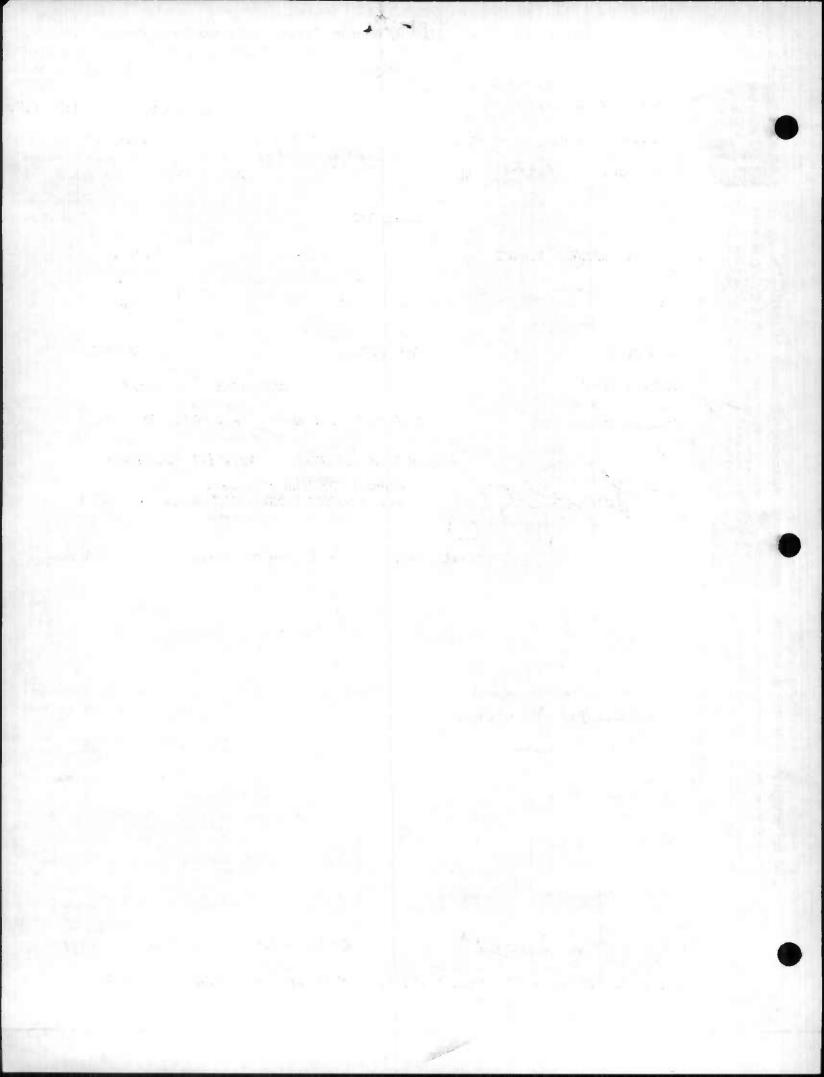
State of Maryland / Department of Health and Mental Hygiene 0.7

					Certin	ficate of	Death		Reg. No.	1 3	0913
Physicia /Medica	_	1. Decedant's Nama (First, Middla, I ELIZABETH A.	•	1				2. Data of De Month OCTOBE	Day	Year	Tima of Death  11:30 A.
Examine	_	4a. Facility Nama (If not institution, g GENESIS ELDERCA					4b. City, Town, or CATONSVI			of Death	i.
Funeral Director		5. Social Security Number 214-70-7541		Aga (In yrs. las		f Undar 1 Yaa fonths Day	r If Undar 24 Hrs.		th y, Year)		(Stata or Foraign
show		Usual Residence of Decedant  10a. Stata 10b. County		10c. City, 1	Town or Locati					10d.	Inside City Limits
Sa-f sho offfied at	Director		I/A		BALTIM	IORE					Yas 2□No
5 8		10e. Street and Number 201 S. BENTALOU	STREET			10f. Zip Coda 2	1223		10g. Citizen of	What Country?	
	by Funeral	11. Marital Status  1 Navar Married 2 Married 3 33Widowed 4 Divorced	12. Was Decedar Armed Forces	s? ] No			Hispanic Origin? (S ban, Maxicen, Puart	pecify Yas or No o Rican, atc.)		ce - Americen I ck, White, atc.	ndlan,
than 'natur the Medicat	Be Completed	15. Decedent's (Spacify only highast g Elementery/Secondery (0-12) 6TH GRADE	Education rada completed) College (1-40	r 5+)	16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use refired)  HOMEMAKER						
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the man		19e. Informant's Name/Ralationship JACK HEINECKER (					at and Number or Ru LLL ROAD		or, City or Town	Steta, Zip Co.	
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s after de	Certification:	3 Suicida 6 Could not 4 Homicida detarmine	d 28a. Place of I	njury - At home atc. (Specify)	a, farm, streat,	, factory, office	Ð	28f. Location (3 City or Tox	Street and Num. vn, Stata)	ber or Rural Ro	outa Number,
within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 12 Certifying F	hyaician: To the bes miner: On the basis and mannar:	of examination	edga, daath oo n end/or invest	curred at tha ligetion, in my	tima, deta and piece opinion, daath occu	, and due to tha rred at tha tima,	causa(s) end m date and place,	ennar as stete and due to the	d. cause(s)
Toth	W	29b. Signetura and titla of certifier	howy	MD			nsa number 40521		29d. Data signe Octobe		
2		30. Name and addrass of person wh				nt)				21229	

State Registrar

31. Data filed (Month, Dey, Yaar)
OCT 15 1997

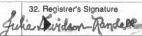
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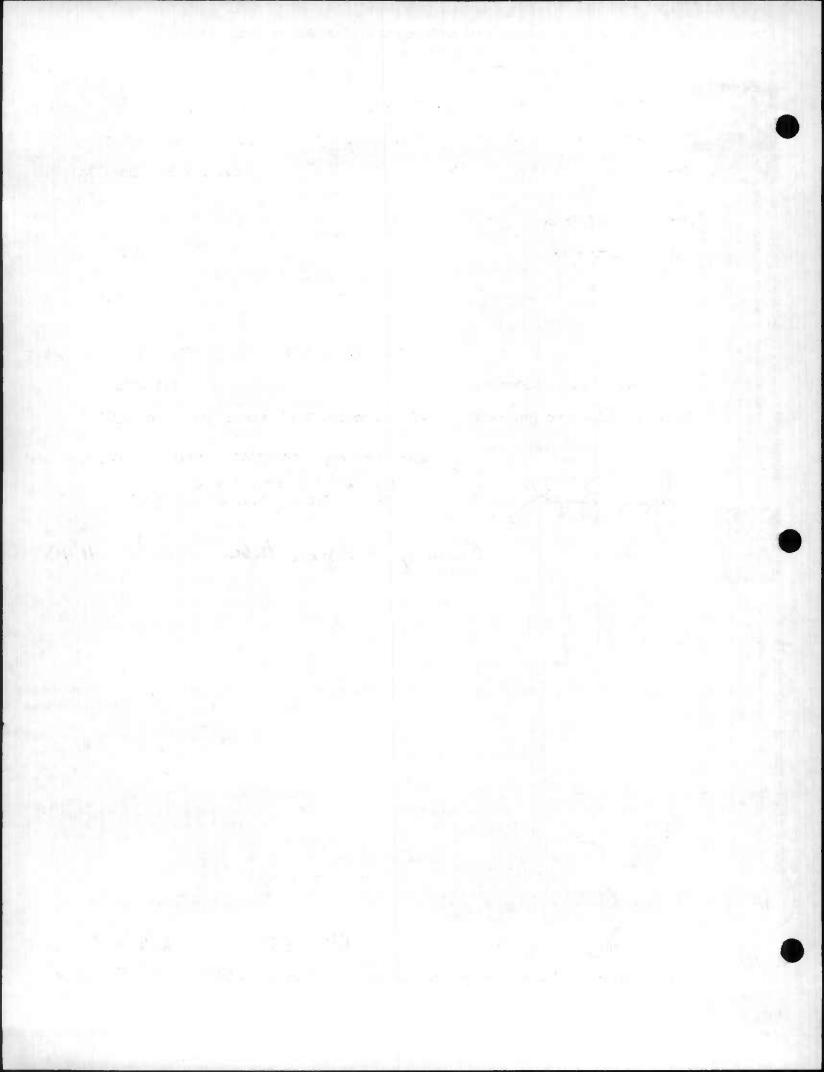


State of Maryland / Department of Health and Mental Hygiene 30976 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 9,1997 **Physician** Lillian S. Helldorfer 6:00 pm October /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Meridian Franklin Woods Nursing Ctr. Rossville Baltimore 5. Sociel Security Number If Under 1 Yaar | If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) NOV.5, 1926 9. Birthplace (Steta or Foreign Country) Maryland 7. Age (In yrs. lest birthday) **Funeral** 1□M 2√2 F Days 219 22 1369 70 Yrs. Director Usuel Residence of Decedent the Maryland 10e Stete 10b Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 2219 Wicomico Road 21221 Norms 23a USA Funeral 12. Wes Decedent Evar In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - American Indien, Bieck, Whita, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Haalth and Maniel Hygiena. Important: If Item 27 is marked other than "natural". A sary injury or other traumatic average. 1 Yas 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 M Married 1 ☐ Yes '2 DNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede comp 16b. Kind of Business/Industry grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Concert Pianist Piano & Organ Teacher 17. Fathar's Name (First, Middla, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John C. Schmeiser Mary S. Baurenfiend 19e. Informent's Neme/Relationship (Type, Pnht) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Francis Helldorfer (husband) 2219 Wicomico Road Essex, Maryland 21221 20e. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, Stete 1 Buriel 2 □ Crametion 3 □ Ramoval from State 4 □ Donetion 5 □ Othar (Specify) Parkwood Cemetery 10/13/97 Baltimore Co., Maryland natura of Furl Tra Servica Licensee 22. Name end Address of Facility
Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Essex, Maryland 21221 23a Pelt 1. Enter the disease, or complications is et caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haert feilure. List only one cause in each line. **Physician** Fullepian Jule Immediate Ceuse (Finel disease or condition resulting In deeth) /Medicai 486 Examiner Physician/Medical Examiner attanding physician and for use es the burial-transit The law requires that the death certificete be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): P.O. Box 68760, Due to (or es a consequenca of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24a. Wes en autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No mis certificata Division of Vital Attending Physician: director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 41 Nursing Home 5 Recidence 6 Other (Specify) 2 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) edicai Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Alber 5 Pending investigation 1 XNeturel 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be determined Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner es steted. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred et the lime, dete and place, end due to the ceuse(s) end manner steted. 29b. Signature and title of certifier 29c. Licansa number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NYO TITA 1 6830 HOXPITAL DRIVE HORPITAL DRIVE, STE 206, BALTU, MD Z1237 31. Dete filed (Month, Dey, Year)

State Registrar

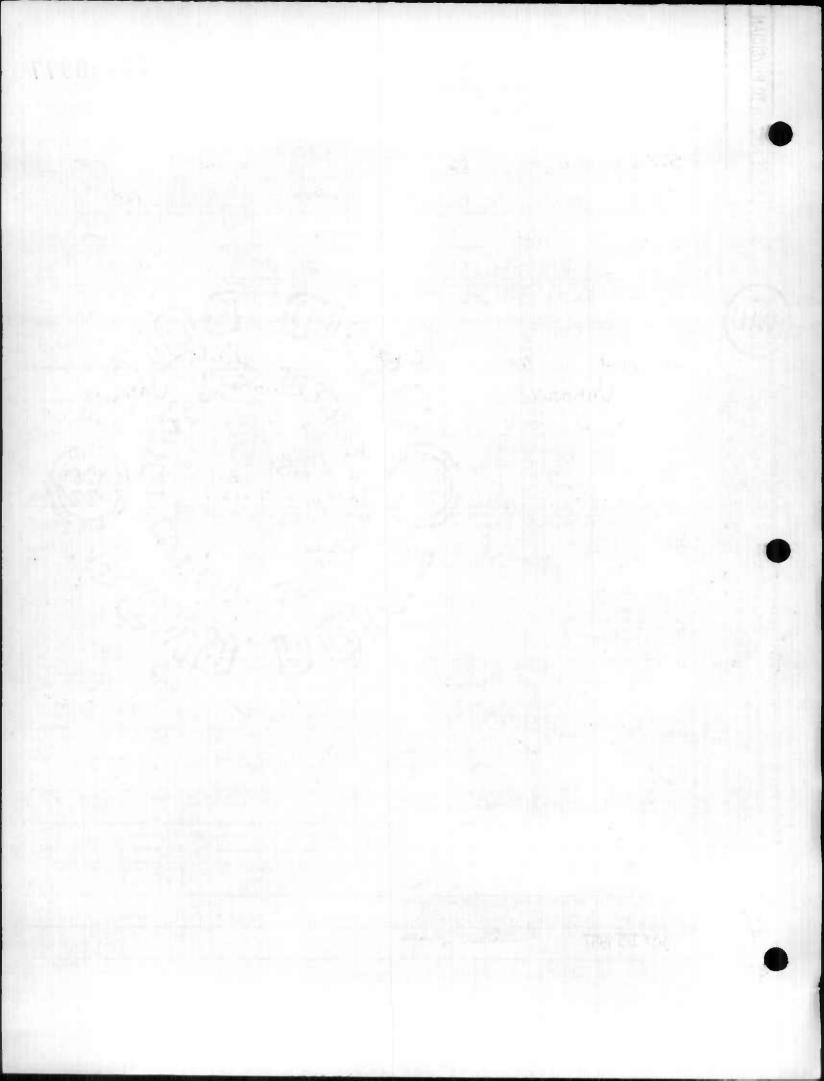




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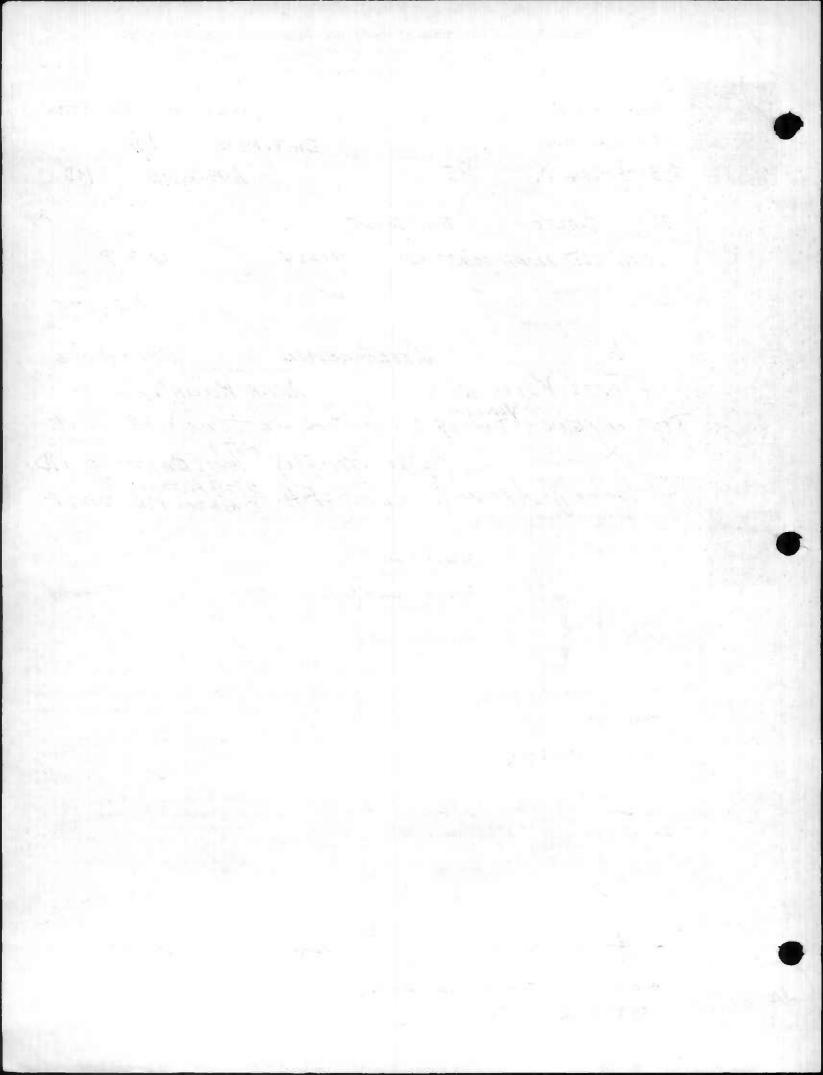
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FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF HEAD		NTAL HYGIEN		
1. DECEDENT'S NAME (First, Middle, Les MACK &	ASTER			2.	DATE OF DEATH MONTH		797 1110 A
4. SOCIAL SECURITY NUMBER 577-03-0089	0110		UNDER 1 YEAR IF	INDER 24 HRS. 7.	DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	o street and number) ome Hosp	98	Ba H	CATION OF DEATH		9c. COUNTY	V OF DEATH
RESIDENCE OF DECEDENT 10e. STATE 10b. COU	NA	1	own or Location Salf More	_			10d. INSIDE CITY LIMITS? 1 TES 2 NO
1807 E. 3	oth St.		101. ZIP	CODE 21218		10g. CITIZE	N OF WHAT COUNTRY?
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 PNO	If yes, specify	ENT OF NISPANIC Cuben, Mexicen, P NO Specify:	ORIGIN? (Specify Yourto Rican, etc.)	os or No — 14	4. RACE — American Indian, Black, Whita, etc. Specify: Black
15. DECEDENT'S E (Specify only highest gn Elementary/Secondary (0-12)	DUCATION Ide completed)  College (1-4 or 5+)	18e. DECEDENT'S US (Give kind of work life. Do NOT use in	done during most of	working	Railn		STRY
17. FATNER'S NAME (First, Middle, Last)			18.	MOTHER'S NAME Leno	(First, Middle, Maide	n Sumamet	Known
190. INFORMANT'S NAME (Type/Print)  Venus D.	Harris	196. MAILING AD	DORESS (Street and N	Imber or Rural Roul			ode)
20e_METHOD OF DISPOSITION 1		PLACE AND DATE OF I			DATE 20c. L	OCATION - CH	ty or Town, Stata
21. SIGNATURE OF FUNERAL SERVICE	7	3.70	1	DORESS OF FACILI		nove 1	
23. PART I. Enter the diseases, a shock, or heert fellur IMMEDIATE CAUSE (Final disease or condition resulting in death)	or complications that caused so. List only one cause on each	the death. Do not chiline.			a cerdiac or res	piratory arres	Approximate interval Betwee Onset and Deal 2 Week
Sequentielly list conditions, if any, leading to immediate ceuss. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in desth) LAST	C <sub>v</sub>	CONSEQUENCE OF):					
PART II. Other significent conditions	d. Jone contributing to death be Tenal Failur	it not resulting in	the underlying ce	use given in Pa		N AUTOPSY DRMED?	24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CON	TRIBUTE TO CAUSE OF	DEATH YES		JNCERTAIN			1 - YES 2 10 40
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	8. PLACE OF DEATH	(Check only one)  THER:  Nursing Home 5	☐ Rasidence 6 [	Other (Specify)		
27. MANNER OF DEATN  1 Natural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME (	OF 28c. INJURY		Id. DESCRIBE HOW	INJURY OCCU	PRED
3 Suicide 6 Could not 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Speci		et, factory, office	2	Bf. LOCATION (Stree City or Town, Stel		r Rural Route Number,
CONSCR DRAY	YSICIAN: To the best of my knowl						
29b. SIGNATURE AND TITLE OF CERTIFICATION .	FIER Ded - Spe	cialist	29	LICENSE NUMBER	C.	≥ OCI	SIGNED (Month, Day, Year) FOBGR 7,199
JOHANGUNTUM.  30. NAME AND ADDRESS OF PERSON  WENEUSA NAV	MARO MD. /	OON. BA	oalceay	Ba	Thomas	Ham	yland 21231



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 7

		1. Decedent's Nem	ne (First, Middle, Last	)	OG.	rtificate (	Dealli	2. Dete of D	Reg. No.		3. Time of 0	Death
Physicia		Malder	. Kosinski					Month	Dey	Year	11:21 A	
/Medic Examin			If not institution, give	street and number)			4b. City, Town, o				11 2114	1
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Funeral		5. Social Security N			n yrs. last birthdey)	If Under 1 Ye		MOKE S. R Date of B	irth	9 Rintho	lece (Stete or	Foreign
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death with the Maryland rms 23a or 28a-f show	٥٢	10e. Stete	10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside City	
Sa-f	3ctc	MD.	DACT	0.	I=ASI P	DINT					1 162	NE NO
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ath w	ral	1046	OLD A	OFTH FOIL	17 RD.	7	21224		0.	5.4		
or its	by Funeral Director	11. Marital Status  1 Never Marr  3 Widowed	ried 2 Married	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		Was Decedent If Yes, specify 0 1 ☐ Yes 2 ☐	of Hispenic Origin? ( Cuben, Mexican, Pue No Specify:	Specify Yes or N into Rican, etc.)	o- 14. Rad Bled	e - Americok, White,	en Indien, etc.	
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filed with Hygiene. ther than		17 Father's Name	(First, Middle, Last)		WITE	EMONS	EMAN 18 Mathor's No	ama /Cirot Middle	e, Meiden Sumen	-	USE	
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should and Man marke umatic		19a, Informent's N	ame/Relationship (Ty	Pe, Priny WOND	19b. Mailir	ng Address (St	reet end Number or F		-	Stete, Zip	Code)	
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permit. Page Depertment of Important: If any Injury or once.			heral Service Ligens	00 / 1	20 22	2. Name and Ad	idress of Facility	1997	DATI	0 0		ال
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ettending for use e	Physician/M											
the da	ysic	Part II. Other eignif	ficant conditions con	ntributing to death but no	ot resulting in the u	inderlying cause	given in Part I.	23b. Did	l tobacco uee co	ntribute to	the cause of	deat
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law require as been si 12 should b	Completed	Ticlam	Foilvre	paty.				24a. Wei	s an autopsy ormed?	ave	ere autopsy fin alleble prior to impletion of cei death?	
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ician: The certificate rector, pag		35 Was seen rates	red to medical						Yes 211No	11	Yes 2□N	10
Physician: this certific ral director,	Be	25. Was case refer exeminer?		fospital:			Other	eath (Check only				
E E	.To	1 Yes 227. Manner of Deat	110	1 L Inpalient	28b. Time of		4 Li Nursing		how injury occur		Y)	
or Attending Phatter death. Director: After th	cation	1 □ Naturel 2 □ Accident	5 Pending investigation	28a. Date of injury (Month, Day Ye.	ar) Injury		njuryet Work? 1 ☐ Yes 2 ☐ No	Zou. Describe	rnow injury occur	100		
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Sulcide 4 Homicide	6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	reet, factory, off	ice		(Street end Numb own, Stete)	er or Rura	l Route Numb	er,
To the Hospital or within 24 hours after To the Funeral Dir completely filled In	edical	29a. Certifier (Check only one)	1 Certifying Phys	sician: To the best of my nar: On the besis of exa and menner stated.	y knowledge, death mination and/or inv	h occurred at the vestigation, in n	e time, date and place ny opinion, death occ	ce, and due to the curred at the time	cause(s) and ma , dete and place,	inner as st and due to	ated. the cause(s)	
	M	29b. Signeture end	title of certifier	end monitor stateg.		29c. Lic	ense number	T	29d. Date signe	d (Month. I	Dey, Year)	pa-
ithin dithin on the comple							-			recept	/	
To the within 2 To the comple		M		Relident			TTSPU		October 3	1917		
To the within 2 To the Comple		30. Name and addr		Reliabent Impleted cause of death	(Item 23a) (Type,	Print)	rrspu		October ?	1917		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Yaar CHARLES HUBERT LUMPKINS OCTOBER 13,1997 6:30pm /Medical 4a. Facility Neme (If not institution, give straat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1000 Spangler Way Baltimore If Undar 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) March30, 1944 5. Social Security Number 7. Aga (In yrs. last birthdey) 9. Birthplaca (Stata or Foraign **Funeral** Days 1**2**0 M 2□ F Country) Ohio 212-42-1724 53 Yrs. Director Usual Rasidence of Decedant the Marylend 10a. Stata 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Insida City Limits n/a Md. Baltimore Director 1 TYas 2 □ No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1000 Spangler Way 21205 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☑ Yas 2 □ No If Yas, Giva Yaar or Detes: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indien, Bleck, Whita, atc. 11. Marital Stetus filed within 72 hours efter 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedant's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacadant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry nd Mentel Hygiene. marked other than Elemantary/Secondary (0-12) Collage (1-4or 5+) 12th Boiler Maker Constraction 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meidan Sumama) Be Peges 1 end 2 should be 1 nent of Health and Mentel I Charles W. Lumpkins Verna Irene Ritchey Important: If hem 27 le manual important: If hem 27 le manual eny injury or other trauma 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Irene Lumpkins / wife 1000 Spangler Way Baltimore Md. 21205 20b. Placa of Disposition (Name of cematary, crematory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cramation 3 Ramoval from Stata permit. Pege Department of Meadowridge Cemetery 10/17/97 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore Md. 21. Signatura of Funaral Sarvica Licansaa 22. Nama end Address of Fecility Connelly Funeral Home of Essex 23a. Part 1. Enter tha disaasa, or complications that caused the death. Do not after the mode of dying, such as cardiac or respiratory errest, 21221 shock, or heart failure. List only one cause on each line. Approximata Intervel Batween Onset and Death **Physician** /Medical Immediate Ceusa (Final 2 cum diseesa or condition rasulting in daath) Examiner Examiner cardio my orate physician end s the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leeding to Immadiate causa. Enter Underlying Causa (Disaasa or Injury thet initieted events rasulting in daath) Last Dua to (or as a consequenca of) P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Ware autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? page 2 s 2 No 1 TYas 2 No certificate Division of Vital To the Hospital or Attanding Physician: Be 25. Was casa rafarrad to medical examinar? 28. Place of Deeth (Chack only ona) Hospital: 2 No Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To 1 Yes 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? After 1 Naturel 5 Panding Invastigation s after death. 1 Yes 2 No 2 Accidant filled in by the 3 Suicida 8 Could not ba 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 24 hours Modical Examiner: To the basis of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted.

Modical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29a. pietely rithin 2 29b. Sig 29c. Licensa number 29d. Dete signad (Month, Dey, Yaer)

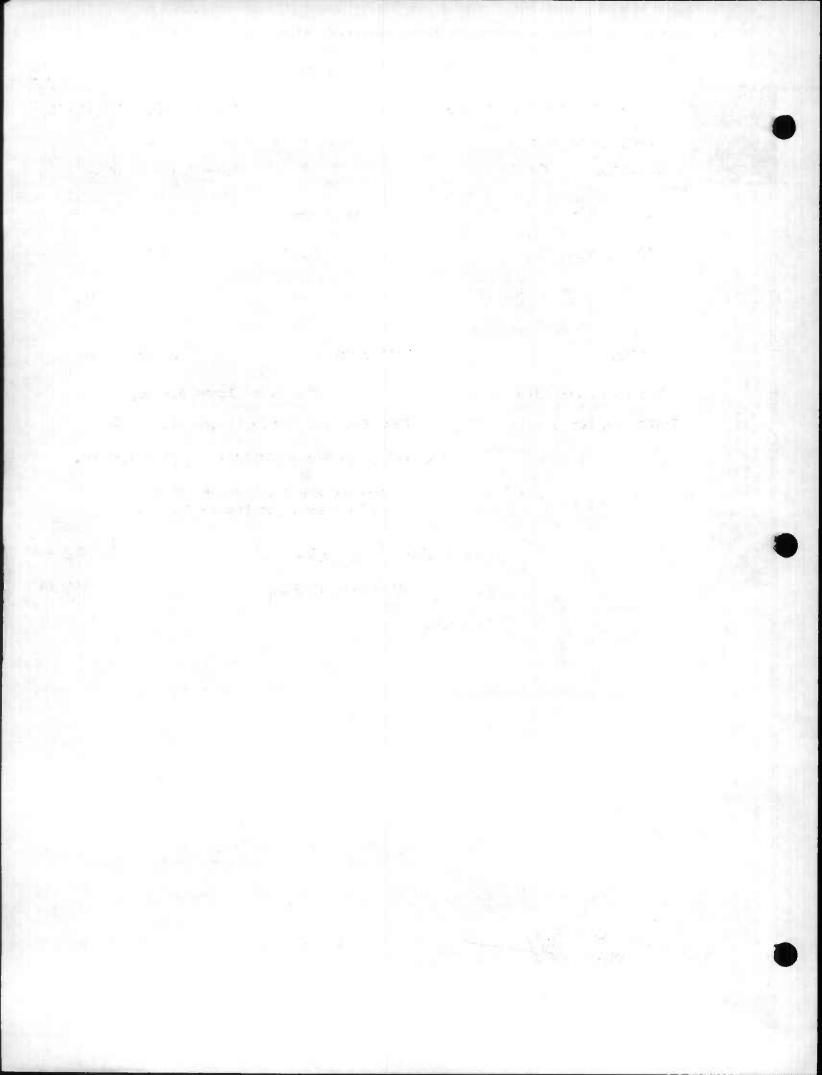
State Registrar

(31. Data filed (Month, Dey, Yeer)

32. Registrer's Signatura

Cur 5

plated cause of death (Itam 23a) (Type, Print)



DARYL LUTTRELL

21	
97	30980
е	e Q7

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

**Funeral** Director ral', or items 23a or 28a-f show Examiner must be notified at the "natural". the Medical

should be filed within and Mental Hygiene. 12 should be fi h and Mental H Is marked ott of Health othar 1 it. Pages 1
artment of H
ortant: If ite permit. Page Department of Important: If any injury or

Baltimore, Maryland 21215-0020

**Physiclan** /Medical Examiner

Examine and physician a the burtal Box 68760 Physician/Medical P.O. signed by t Records. à Completed 9080 vision of Vital Be 10 Ē Certification: settor: Atten

Month 8, DARRYL LUTTRELL **OCTOBER** 1997 9:51P.M. 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death SHOCK TRAUMA CENTER BALTIMORE If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) 1 M 2□ F 212-94-8277 20 Yrs. FEB 18, 1977 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A 1 Yes 2 No Director BALTO 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2322 E. FAYETTE ST 21224 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) llth N/A RESTAURANT COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HANK FLEMMING RENEE LUTTRELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 2322 E. FAYETTE ST BALTO, MD 21224 RENEE LUTTRELL 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OCT 16 MT. ZION CEM 1997 4 ☐ Donation → ☐ Other (Specify) BALTO, MD 21. Signature of Feneral Service Licenses 22. Name end Address of Facility BETTS FUNERAL HOME 1129 N CAROLINE ST BALTO, MD 21213 altica 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel wound to chest Stab disease or condition resulting in death) Due to (or as a consequence of) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Was an autopsy completion of cause of deeth? 1 Yes 2 No LPYYes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 No Hospital: 1 ☐ Inpatient ② ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 1 Natural Injury 5 Pending 1 Yes 2 □ No investigation 10-8-97 2126 M 2 Accident Subject was Stabbed 281. Location (Street and Number or Rural Route Number, City or Town, State) 30 | Light Street 6 Could not be determined 3 🗆 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Stephen S, Radentz, MD 31. Date filed (Month, Day, Year) Luka Devidson-Kandell

Phillips

Restaurant

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23d) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

Baltimore City, Maryland

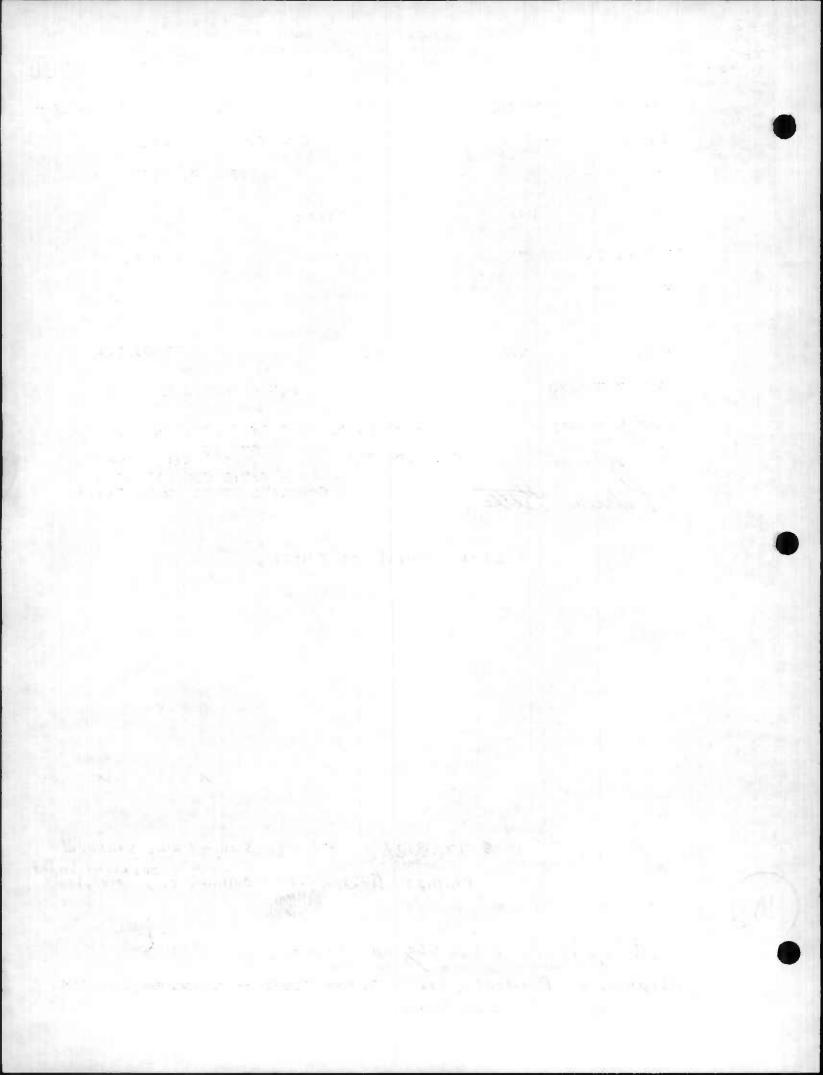
29d. Date signed (Month, Day, Year)

OCTOBER 9, 1997

4 Homicide

29b. Signature and title of certifier

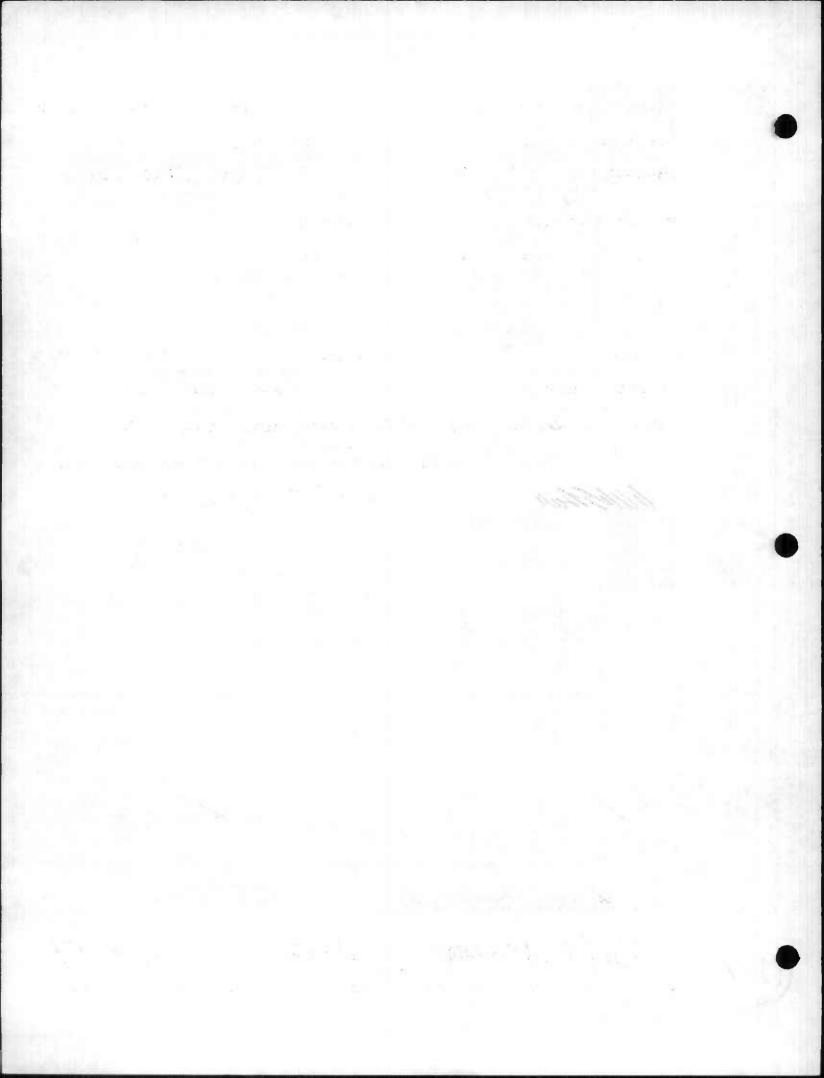
29e. Certifier (Check only one)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death October 12, **Physician** Irene Clementine LaPole 1997 10:42 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 18 Chatterly Court Perry Hall Baltimore H Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month Day, Year) April 8, 1905 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months 1□M 20 F 92 213-20-3789 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heaith and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified as 10d. inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Perry Hall 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 18 Chatterly Court U.S.A. 21128 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Meritel Stetus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: f Yes, Give Year or Dates: White à Specify: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Seamstress Clothing Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Burrall Harvene (surname unknown) 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur D. LaPole, Sr. 25 Deep Channel Drive, Berlin, MD (son) 21811 20b. Pieca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriai 2 💆 Cremetion 3 ☐ Removel from State Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 10/15/97 Baltimore, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 24 hous Examiner Examine Physician and the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Box 68760 ġ Physician/Medical Due to (or es a consequence of) ä 985 P.0. ž Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 | Yes 2 | No 3 | Probably 4 Unknown Division of Vital Records, ģ 24a. Wes an eutopsy performed? 24b. Were sutopsy findings Completed 5 aveilable prior to completion of cause of death? certificate has page 2 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? 28. Place of Death (Check only one) Hospitel: Other: 4 ☐ Nursing Home Standarde 8 ☐ Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day Year) 28b. Time of Injury gueun 27. Manper of Death 28d. Describe how Injury occurred Certification: 28c. injury at Work? Natural 5 Pending Investigation death. 1 Yes 2 No d or Attendante after death Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, tarm, street, tactory, offica building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d, Dete signed (Month, Dav. Year) -64 30. Name and andress of person impleted cause of death (ttem 23a) (Type, Print) TRG 4 MO 100L BELAIN RO., BAKTO. MD 31. Date tiled (Month, Day, Year) 32. Registrar's Signature OCT 15 1997 Registrar

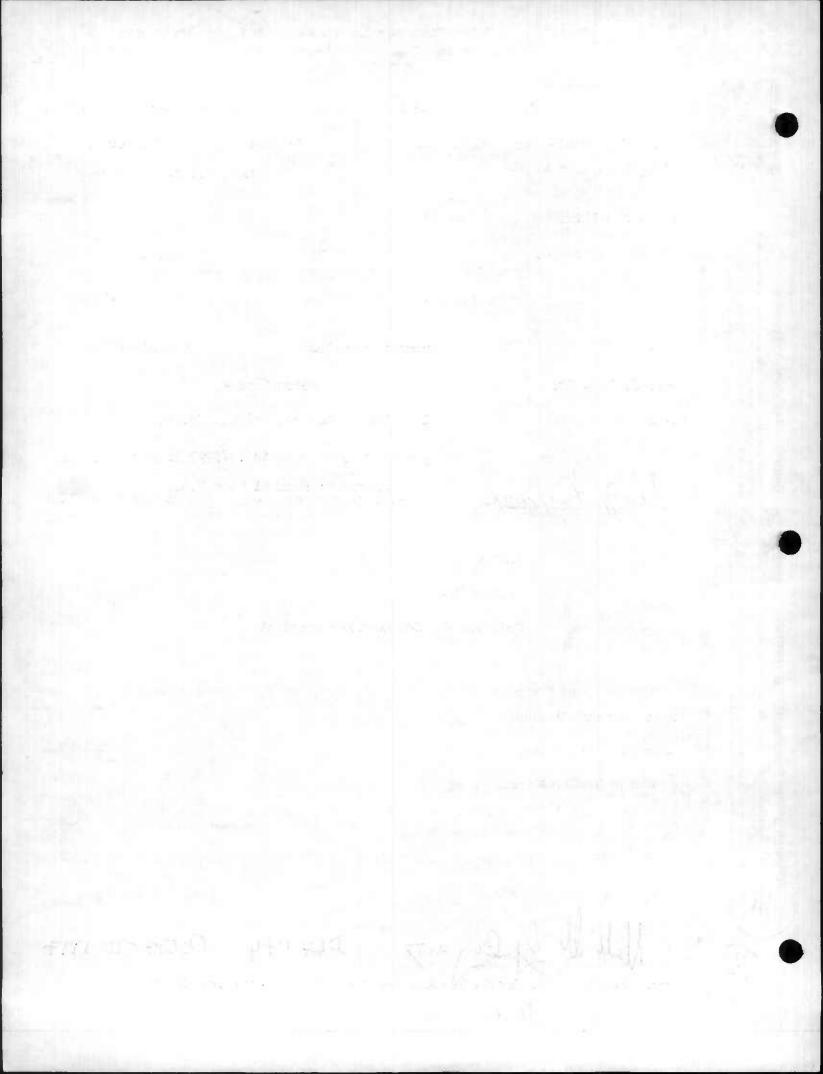


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 2. Dete of Death 3. Time of Deeth Month Yaar **Physician** LONG JR. David October 10, 1997 5:50 am /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Franklin Square Hospital Center Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foraign Country) **Funeral** 1 M 2□ F Deys 213 28 9810 Yrs. Director Oct. 1,1932 Maryland Usual Residence of Decedant 10e Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show so filed within 72 hours effer death with the Marylar at Hygiene.
Tother than "naturel", or items 23s or 28s-f show went, its Medical Examine must be notified at went, 1 ☐ Yes 2 No Maryland Baltimore Middle River Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2209 Souththorn Rd. 21220 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ½ Yes 2 □ No If Yes, Give Yaar or Dates: 1951/54 Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Bleck, Whita, atc. 11. Marital Status 1 Naver Married 20 Married 21215-0020 1 Yes 2 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highast grade completed) Elementary/Secondery (0-12) College (1-4 or 5+) Machine Operator Communications treumatic event. Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) d 2 should be fi h end Mental H 7 Is marked ott Be David C. Long Sr. Helen Gietka 2 19a. Intormant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Numbar or Rural Route Number, City or Town, Steta, Zip Code) permit. Pages 1 and 2.
Department of Health e.
Important: If Item 27 1s
any injury or other treu 2209 Souththorn Rd. Balto., Md. 21220 Dolores Long (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Nema of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 1 X Burlel 2 ☐ Cremetion 3 ☐ Removal from State Holly Hill Mem. Gardens 10/13/97 Baltimore Co. Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Addrass of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 nn JUTKOUSKO PIn1. Enter the disaasa, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. **Approximate** ervel Between Onset and Deeth **Physician** /Medical Immedieta Ceuse (Final disease or condition resulting in death) Pneumonia Examiner Due to (or es e consequence ot): Examiner Aspiration that the death certificete be executed buriei-tran Sequentially list conditions, if any, leeding to immadiate cause. Entar Undarlying Ceusa (Disaasa or injury that initiated events resulting In daath) Last end Due to (or as e consequence ot): Box 68760. ed by the ettending physician deteched for use es the burie Multiple Cerebrovascular Accidents Physician/Medical Due to (or as a consequence ot) P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 12 Yes 2 No 3 Probably 4 Unknown Multi-Infarct Dementia Division of Vital Records. g The law requires Completed 24b. Wara eutopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Chronic Renal Failure this certificate 2 No 1 □ Yas 2 □ No Diabetes Mellitus or Attending Physicien: funeral director, 25. Was case reterred to medical exeminer? Be 26. Placa of Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation After 1 Netural 1 □ Yes 2 □ No death 2 Accident efter death Director: the 6 Could not be determined 28e. Piece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 2 4 Homleide 12 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) end mannar as statad.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar statad. 29e Cartifier Medical 29b. Signature and titl 29c. License numbar 29d. Date signed (Month, Dey, Year) 30. Name and addrass of parson who em 23a) (Type, Print) 9000 Manklin Square Drive Mark McGinley Baltimore, Maryland 31. Date filed (Month, Day, Year) 32 Registrer's Signeture

Registrar

State

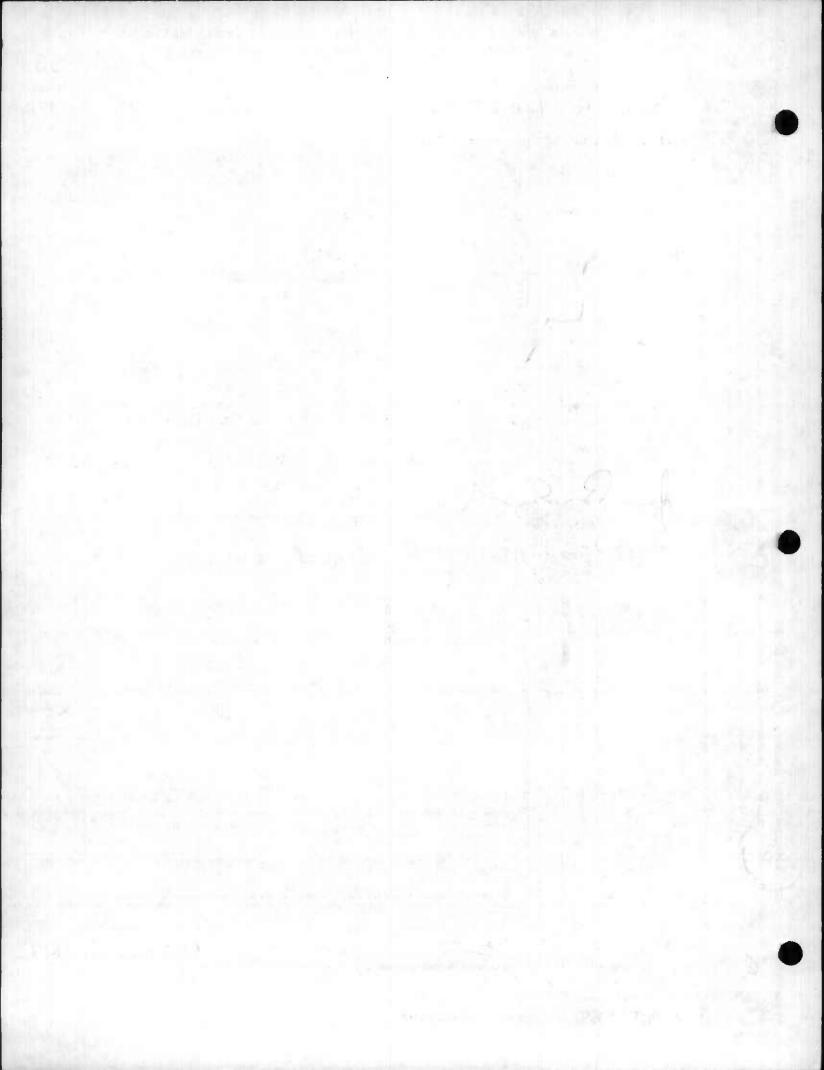
**DHMH 16 Ray 6/95** 



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** YOUL 9:37 pm Lankford OCTOBER 10 1997 /Medical 4e. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Daath Stella Maris Hospice at Mercy Baltimore If Under 1 Yaar if Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) Aug. 23, 1952 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. lest birthday) 9. Birthplace (State or Foraign **Funeral** 10 M 20 F Months Yrs. 45 Director 218 60 7868 Mary land Usual Rasidance of Decedant 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Insida City Limits the Medical Examiner must be notified at Maryland Baltimore Middle River Director 1 Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 6 238 1505 Aldney Ave 21220 USA items. 12. Was Dacadent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas: 11. Marital Stetus 13. Was Dacadant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 72 hours after 1 Naver Marriad 2 Married 21215-0020 "natural", or 1 ☐ Yas 2 ☒ No Specify: by 3 ☐ Widowed 4 € Divorced Specify: White Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry e filed within 7 al Hygiena. Eiamantary/Secondary (0-12) College (1-4or 5+) 10 Owner / Operator Produce - Retail Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maldan Surnama) Be Pages 1 and 2 should be If Item 27 is marked or other traumatic ev William Lankford Baker Lena 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Lisa Rizzo (daughter) 1505 Aldney Avenue Middle River, Maryland 21220 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Oak Lawn Cemetery Oct. 14, 1997 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) nature of Fundral Service Licenses 22. Name and Addrass of Facility Bruzdzinski Funeral Home PA 1407 OldEastern Avenue Essex, Maryland 21221 The the disease or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or raspiratory errest, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final Breast Cancer disaasa or condition rasuiting in daath) years Examiner Dua to (or as a consequance of) Examiner Sequantially list conditions, if any, laading to immadiata ceuse. Entar Undarlying Cause (Diseasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Box 68760. Physician/Medical 8 Due to (or es e consequança of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown b 3 24b. Wara autopsy findings available prior to completion of cause of daath? Completed 24a. Was en autopsy performed? page 2 1 Yes 2 No certificate 1 ☐ Yas 2 ☐ No Vital 25. Was cesa rafarred to medicei Be 26. Placa of Death (Check only ona) STELLA MORIS OT / PC) Other: 4 Nursing Homa 5 Residence 6 Nother (Specify) HOSPICE Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA to 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending 1 Yas 2 No 2 Accident invastigation 3 Suicida 6 Could not be datamined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida Certifying Phyaician: To tha best of my knowledga, death occurred at tha time, dete end piace, and due to tha causa(s) and mannar as statad.

| Medical Examiner: On the best of examination end/or invastigation, in my opinion, death occurred at the time, data and piace, and due to the causa(s) and manner stated. Medical 29a. Certifian (Check only one) 29b. Signeture end title of certifian 29c. License number 29d. Date signed (Month, Day, Year) On auroll 040480 30. Nama and addrass of person who completed ceusa of death (Item 23a) (Type, Print) 5810 Belain 120 FERRO, MO FERNANDO Balto MD 21206 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State who Davidson Registrar



State of Maryland / Department of Health and Mental Hygiene

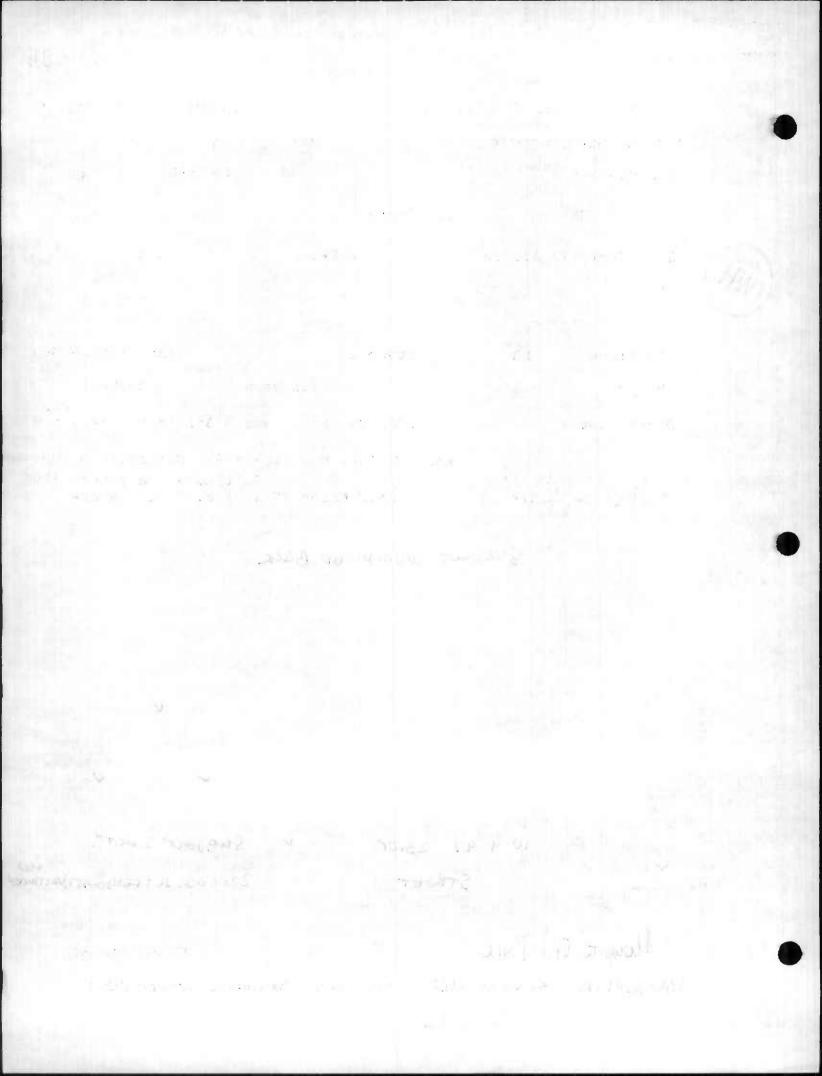
30984

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month 1997 Ja-Wan Derrod Miller OCTOBER 10. 0031AM /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE CITY JOHNS HOPKINS HOSPITAL E.R. If Under 1 Birthpiece (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) If Under 24 Hrs **Funeral** MM 2DF 16 Yrs 213-98-4388 Director Md Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits Md. NA Baltimore 1 Yes 2 No 258-1 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 3025 Mavfield Avenue 21213 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Never Married 2 Married 1 ☐ Yes 2 XNo
If Yes, Give
Year or Dates: Baltimere, Maryland 21215-0020 1 Yes 2₺ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) 君 Lake Clifton Sch. Student 9th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) es 1 and 2 should be il of Health and Mental H I hem 27 is marked off Miller Barbara Herbert Stephen D. 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21213 3025 Mayfield Avenue Baltimore, Maryland Lewis Diane 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Pages Important: If Is any injury or o once. 1 X Burial 2 Cremetion 3 Removel from State 10-16-97 Western Star Cem. Catonsville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23e. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) GUNSHOT WOUND OF BACK Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest pue Due to (or es e consequence of) 68760 Physician/Medical Due to (or es e consequence of): Box ( Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o 3 1 Yes 2 No 3 Probably 4 Unknown signed I Records, by 24b. Were eutopsy findings eveileble prior to 24a. Was en eutopsy performed? Completed completion of cause of deeth? 1 Nes 2 No 1 Yes 2 No Division of Vital Attending Physician: Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 XYes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending Investigation 1 Neturet SHOT. Sugger daath. 97 23501M 1 Yes 2 No aftar daath Director: A 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 2200 BUX JEFFERYOUS MANTHERS 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

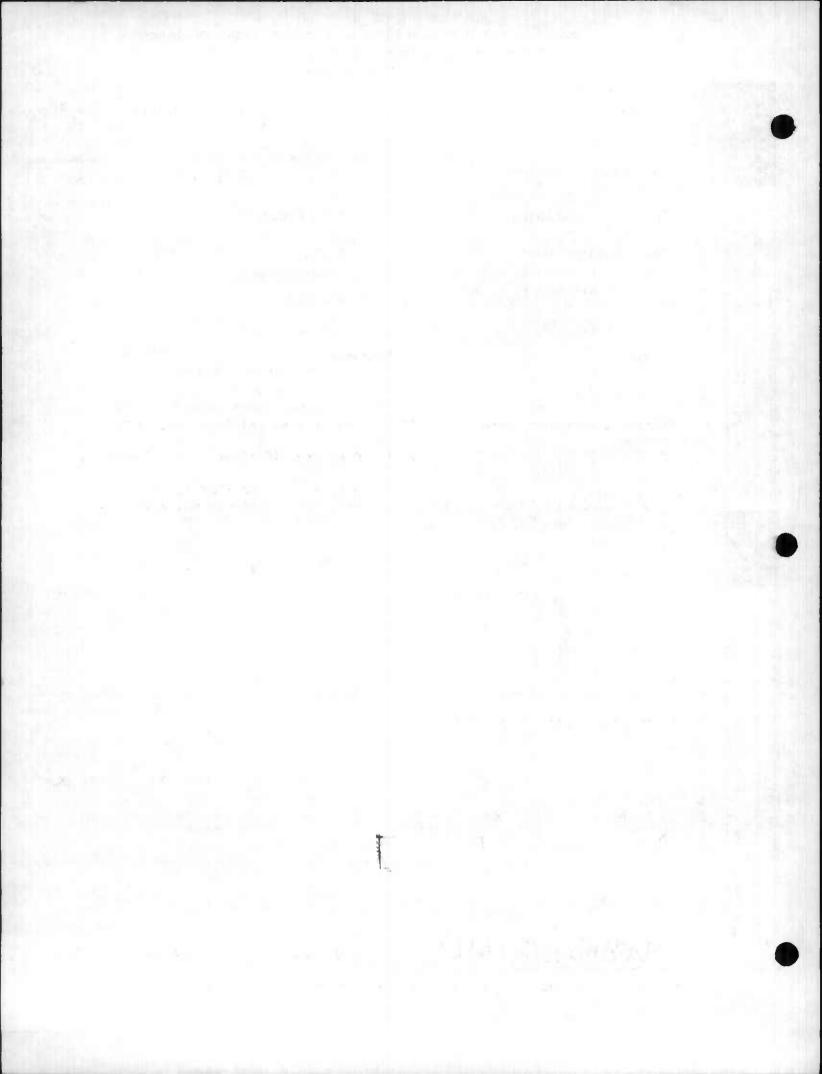
2 Medical Examtner: On the basis of exeminetton end/or threstigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Yeer) O.C.M.E. OCTOBER 10, 1997 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) HARYSMITS Koleu (W) 111 Penn Street, Baltimore, Maryland 21201 OCT 15 1997 32. Registrer's Signeture State

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Registrar



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State of Maryland / Department of Health and Mental Hygiene 97 30986

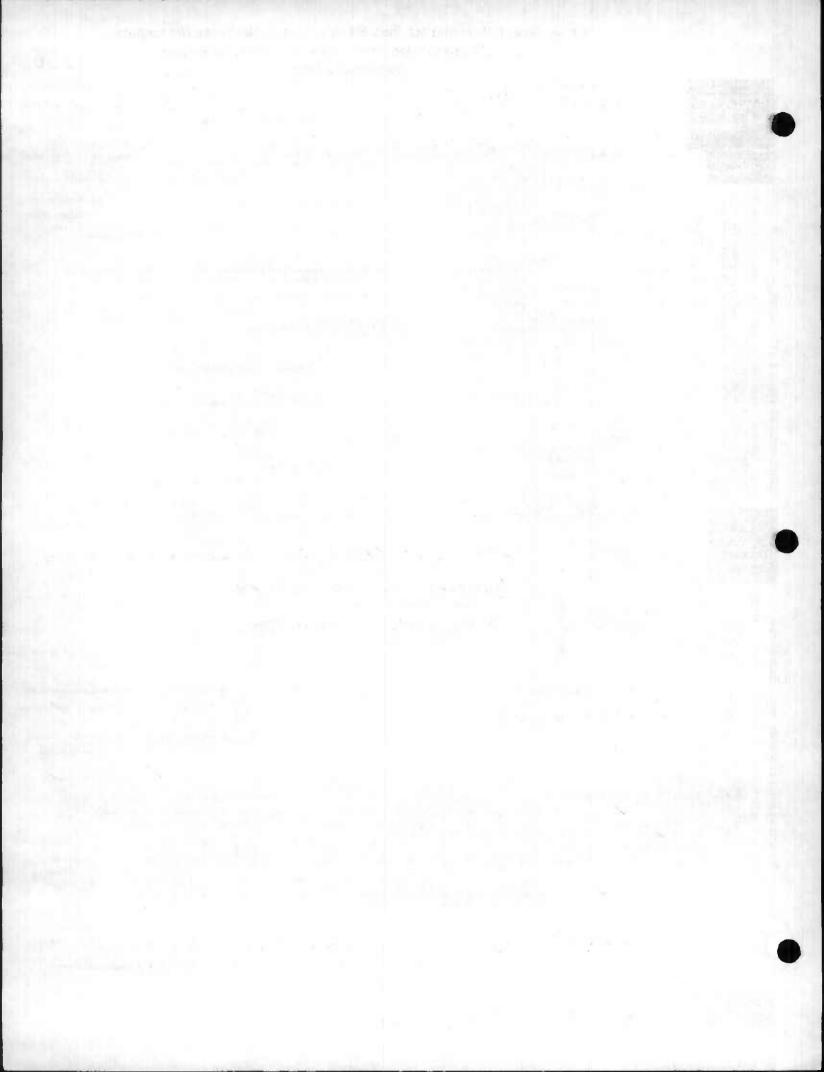
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al", or items 23s or 28s-f shov Examiner must be notified at	Funeral	11. Maritel Status	12. Was Decedent Ever Armed Forces?	in U,S. 13.	Was Decedent	of Hispenic Origin? ( Cuben, Mexican, Pue	Specify Yes or N	o- 14. Rac	ce - American	
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- 1	by	3 Widowed 4 □ Divorced	If Yes, Give Yeer or Dates:		1□Yes 2.8	No Specify:		Specif	Y. BLA	NA
natural', Mical Exp	Completed	15. Decedent's E	ducation	18a. Dece	dent's Usuai Od	cupetion		16b. Kind of B		
F 20	olei	(Specify only highest gro	ade completed)	(Give	kind of work do	one during most of watered)	orking			
than	E	Elementary/Secondary (0-12)	College (1-4or 5+)		MEMA	1.4		17/12/	Hom	E
other than		17. Fether's Name (First, Middle, Last	1	1770	110/1/		ame (First, Middle			
arked or atic eve	Be							1	110)	
marked matic ev	2	PENVAMIN	POWELL				A SMI			
tom 27 is marked other than "nature other traumatic event, the Medical		19a. Informant's Name/Relationship (	,	19b, Maili	ng Address (St	reet and Number or F	Rural Route Numi	per, City or Town	, State, Zip Co	ode)
ther tr		BRENDA JOHN	USON	710	3 HUL	LCT. To	ALTIMO	RE, M	21	244
item 27 other t		20a. Method of Disposition		Ob. Piace of Dispo	sition (Name o	of spinood	Date	20c. Location	- City or Town	, State
nt: If it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removel from State	N	11	10 10	1	57 0	1200	e 111 11
important: If any injury or once.						REM. PARK	1	7		3, W.V.
importa any inju		21. Signature of Funeral Service Licar	nsee / / / /	22	2. Name and A	ddress of Facility	2829 A	UDSON	ST.	
- 60		Henry H.	Skarle 4.	(	) KARDA	2 F-H-	BATIN	LOSE A	UD. 7	21224
sician edicai iminer	лег	immediate Ceuse (Final disease or condition resulting in death)		to (or as a conse	quence of):	K ACUTE MYOPAT		my EDEM		DAYS
nding physician and use as the burlal-transit	Examiner		D			MYOPHI	HY		1	
al-tra	Xa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events		to (or as a consec			,			
bur		Cause (Disease or Injury	c. M900	ARDIM	. /N	FARCTIO.	$\sim$			
phy:	n/Medical	resulting in deeth) Last	Due	to (or es a consec	luence of):					
O G	Me		d							
ettend for us	a									
9 9	Physicia	Part ii. Other significant conditions of	contributing to death but not	resulting in the u	nderlying cause	given in Part I.	23b. Dic	tobacco usa co	ontributa to th	e cause of death
ed by the detached	بار ک	DIARETTE MA	0				1	Yes 2 No	3 Probat	oly 4 Donknov
90	by	O(11150 /23 /418	- LLIIIS							
been signed I should be det		DIABETES ME HUPERTENS						an autopsy	24b. Were	autopsy findings
Sho	et	MUPERIENS	ION				pert	ormed?	comp	able prior to eletion of cause
60 CA	Completed							/	of de	atn /
pad	ပိ						1 🗆	Yes 2 No	101	es 212 No
is certificata director, pay	Be	25. Was case referred to medical examiner?				26. Place of De	eath (Check only	one)		
O S	2	1 Ves 2 No	Hospital:	2 ER/Outpatier	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Res	idence 8 DOtt	ner (Specify)	
		27. Menner of Deeth	28a. Date of injury (Month, Day Yea	28b. Time o	f 28c. I	njury at Work?	28d. Describe	how injury occur	rred	
or: Affer the fune	유	1 Naturel 5 Pending 2 Accident investigation		(r) Injury		1 Yes 2 No				
	Certification:	3 ☐ Sulcide 6 ☐ Could not b	e 28e. Piaca of injury -	At home farm str	reet factory off	Ice	28f Location	(Street and Num	her or Rural R	Route Number
Direct d in by	Te	4 ☐ Homicide determined	building, etc. (Sp.	pecify)	001, 1401019, 011		City or To	wn, State)		
uneral ily fille							1	2.67		
Furn stely 1	edicai	(Checkedly 2 Medical Exar	ysician: To the best of my niner: On the basis of exar	knowledge, death ninetion and/or in	n occurred at the	e time, dete and place	e, end due to the	cause(s) and m	anner as state	ed. e cause(s)
ple	8	Orie)	and manner stated.			,		, with bidge		
20	Σ	29b. Signature and title of certifier			29c. Lic	ense number		29d. Date signe	ed (Month, Da	y, Year)
		HAUM	MD		B	4 443917	18	SEPTEMA	SER 2	9.1997
1		20 Name and address of second		(Name Office of T		MASGEDRAL				
1		30. Name and address of person who		(Item 23a) (Type,			1 10004110	Dal IDan	I VI CO	1.00
		STOT OLD COURT	TO ITY ICHO	TILLSTOW	~ 2	1133				

State Registrar 31. Date filed (Month, Day, Year)

OCT 15 1997

32 Registrer's Signature

June Davidson Gandalle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Month **Physician** Year BRUCE MILLER OCTOBER 1997 8 2:15 PM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE 5. Sociel Security Number # Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** M 2 F Yrs. JULY 10, 1949 Director 202-38-5646 Usuel Rasidance of Dacedant the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at WINCHESTER 1 Yas 2 No Director FREDERICK 10e. Street and Number 10g. Citizen of What Country? 1381 22602 U.S.A cT. Completed by Funeral death 12. Wes Decedant Evar in U,S. Armed Forces? 1 Yas 2 □ No rYes, Giva Yeer or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status filed within 72 hours after 1 □ Navar Married 2 □ Married 21215-0020 1 Yes 2 No Specify: 3 Widowed 4 Divorced WHITE treumstic event, the Medical 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) marked other than Hygiene. PRODUCTION Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) . Peges 1 and 2 should be filt ment of Health end Mental Hant: If Nem 27 is marked oth jury or other treumstic even Be PAULINE E. MILLER SR. C. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) MILLER LEBANON, PA. / ata 20c. Location - City or Town, Stata AUL E. 1146 20b. Place of Disposition (Naria of cematary, cramatory or other place) 20a. Mathod of Disposition

1 Burial 2 Cramation 3 Removel from Stata Data permit. Pege Department of Important: If any Injury or once. 4 □ Donation 5 □ Othar (Specify) MMELLINGS 21. Signature of Funaral Sarvice Licent 22. Nama and Addrass of Facility 21224 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death **Physician** ADULT RESPIROTORY DISTRESS /Medical Immediata Ceusa (Final SYNDROME 15 DAYS diseasa or condition rasulting in daath) Examiner BONE MARROW TRANSPLANT Examiner 15 DAYS The law requires that the death certificete be executed Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undartying Causa (Disaasa or injury that initiated avants resulting in daath) Last pue Dua to (or as a consequence of) c. LYMPHONA Physician/Medicai 10 MONTHS the Due to (or as a consequence of): USB BS ettending Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown þ should be Completed 24b. Wara autopsy findings aveilable prior to complation of ceuse of death? 24a. Was an autopsy performed? page 2 1 Yes 1 Yas 2 No certificate 2 No funerei director, 25. Was cesa rafarrad to medical exeminar? Be 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Yas 2X No 1 Nnpatiant 2 ER/Outpatient 3 DOA After this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Klatural 5 Panding invastigation 1 □ Yas 2 □ No 2 Accidant ofter death the 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, fectory, office building, atc. (Specify) in by 4 Homicida

P.O. Box 68760, Records, Division of Vital or Attending Physicien: To the Hospital within 24 hours e To the Funeral D

> State Registrar

pelli

Medical

IVAN BERRELLO 31. Data filed (Month, Day, Yaar) OCT 15 1997

29b. Signature end titla of certifier

JOHNS HOPKINS HOSPITAL 32 Registrar's Signature year Davidson-Randall

MZ

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

390

600 N. WOLFE ST

29d. Dete signed (Month, Day, Year)

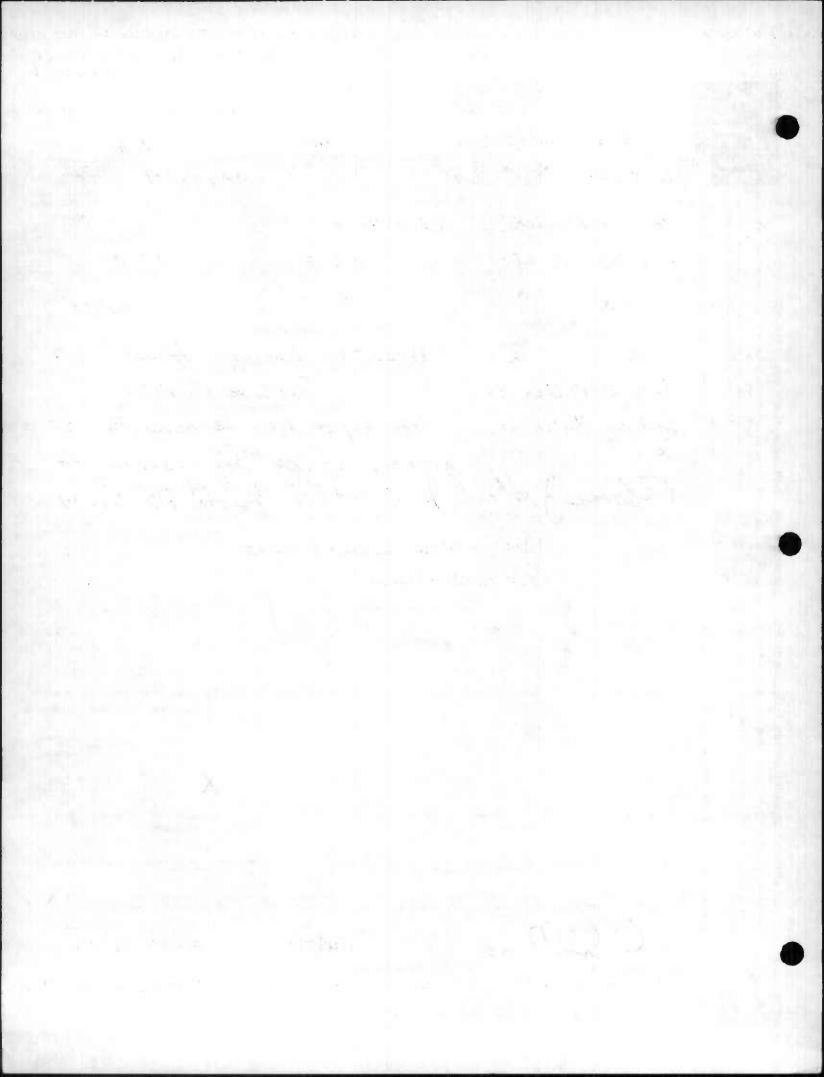
8, 1997

BALTIMORE, MARYLAND 21287

OCTOBER

**DHMH 16 Rev 6/95** 

29a. Certifiar



State Registrar 30. Name and address of person who completed cause of the (Item 23e) (Type, Print)

HOPONE MIKERY

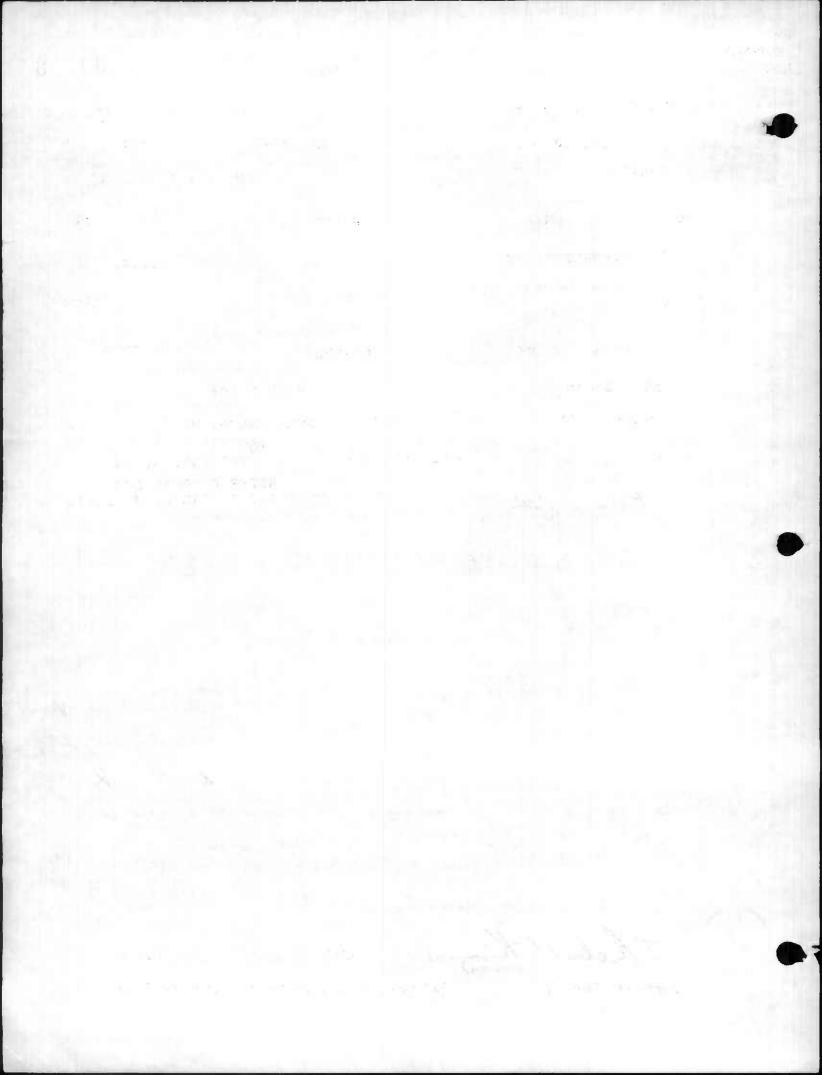
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This 2 Desider & Significant

OCME

111 Penn Street, Baltimore, Maryland 21201

OCTOBER 08, 1997



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2 Data of Death 3. Time of Deeth Yaar McNicha Oct 10 19 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c, County of Deetl Wes tanas If Under 1 5. Social Security Number 7. Age (in yrs. lest birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Day, May 19, Birthplace (Steta or Foreign Country) 10XM 20 F Months Hours 75 213-12-4471 Maryland Usuel Rasidenca of Dacadent 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No Maruland Carroll Manchester 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? 3325 Augusta Road 21102 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yas 2 ☐ No if Yas, Giva Yeer or Datas: WW II 11 Maritai Status 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American indian, Black, Whita, etc. 1 Never Marriad 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elamantary/Secondary (0-12) Coilege (1-4or 5+) Police Officer Steel Company 10th grade 17. Fether's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Surnama) Thomas F. McNicholas Ruth Caulk 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Estelle F. McNicholas (wife) 3325 Augusta Road, Manchester, MD 20e. Method of Disposition 20b. Place of Disposition (Neme of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Meadowridge Mem'l Park 10/14/97 Elkridge, Maryland 22. Name and Addrass of Facility Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21. Signeture of Funerel Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. erval Between heat and Death Immediata Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseese or Injury that initiated avants rasulting in death) Lest ie and Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a Stata

**Funeral** 

Director

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28a-f

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Herms 23a

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"natural".

marked other than

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permit. Pages 1 and 2 is Department of Health ar Important: if Item 27 is any Injury or other trau

Pages 1 and 2 should be nant of Health and Mental

traumatic event, the Madical Examiner must be notified at

Funeral Director

Completed by

Be

2

the Maryland

filed within 72 hours aftar death with

21215-0020

Maryland

Baltimore,

Box 68760,

Division of Vital Records,

2

The law requires that the death certificate P.O.

tigned by

certificate

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Athar

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Physician/Medical à Completed 88 2 Certification:

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 DINO 1 ☐ Yes 2 ☐ No

25. Was case rafarred to medical axaminar? 1 Yas 2 No

1 inpatient Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Dascribe how injury occurred

27. Menner of Deeth Natural 5 Pending Invastigation 2 Accident 3 Suicida 6 Could not be

28a. Date of injury (Month, Day Year) 28b. Tima of

28a. Place of tnjury - At homa, farm, streat, fectory, office building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Yes

28. Plece of Deeth (Check only one)

29a. Certifiar

4 Homicida

🛍 Certifying Physician: To tha best of my knowladga, death occurred at tha tima, data and piece, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end mennar stated.

29b. Signetura end titla of certifier

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of person who complated causa of spath (itam 23a) (Type, Print) lea

31. Data filad (Month, Day, Year)

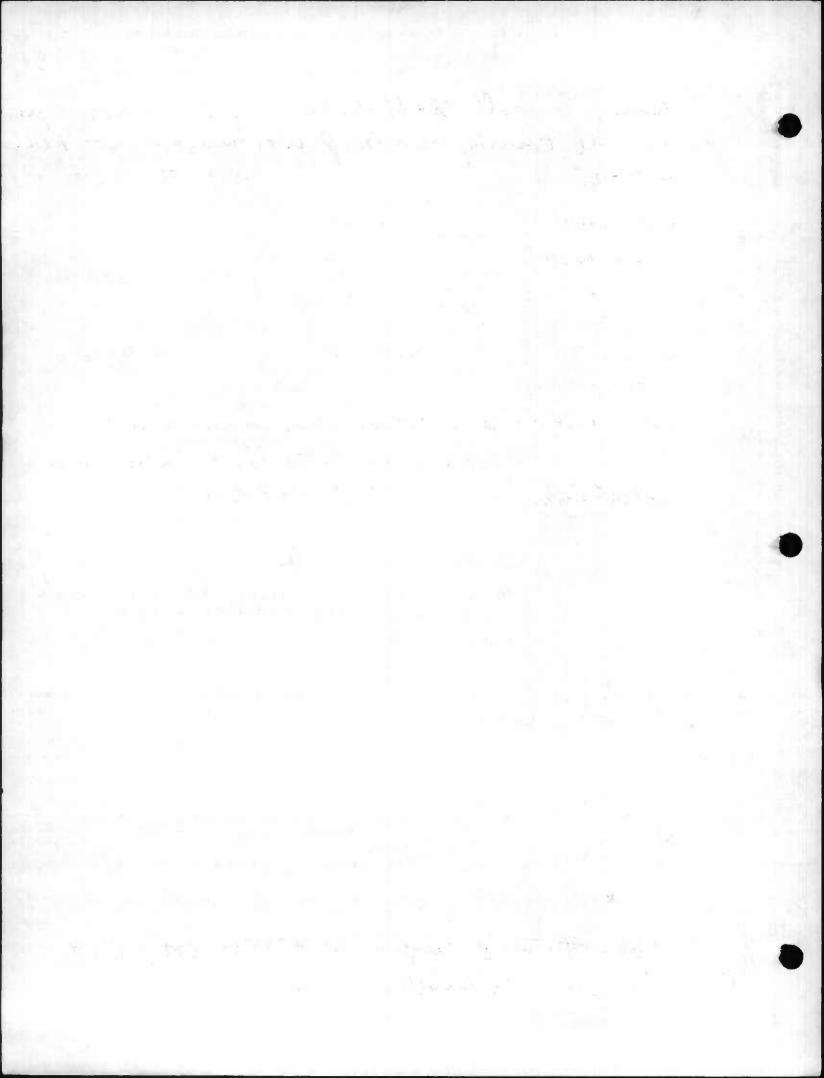
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32. Registrar's Signatura

State Registrar

**DHMH 16 Rev 6/95** 



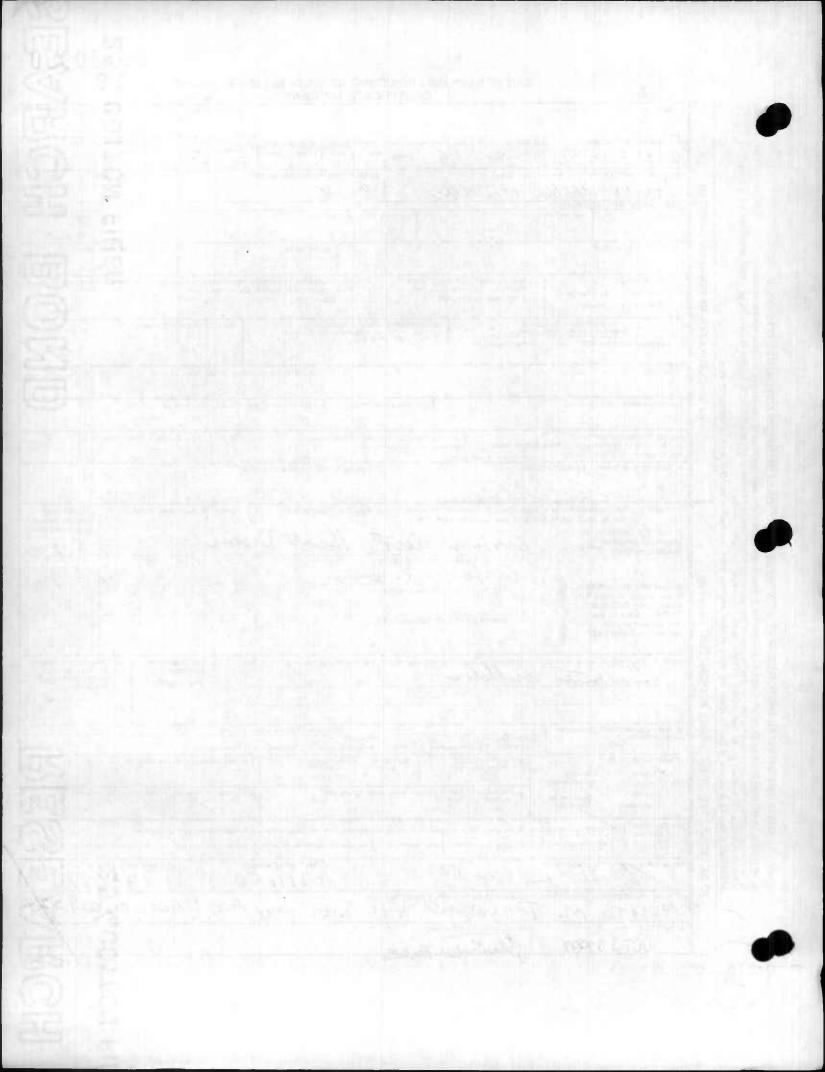
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

1	-	FOR STATE REGISTRAR
	1. D	ECEDENT'S NA

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (FIRST	i, Middle, Last)	n	1USCH	/				2. DATE OF DEATH MONTH D	AY 2	YEAR 6 3	EATH 2
	4. SOCIAL SECURITY NUM	BER	5. SEX	8. AGE (In yrs. les		IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Country)	Foreig
	213 34-1	4341	1 M 2 PF	95	YRS.	MONTHS.	DATE	HOURS WIN.	5-22-0	2	MARYLAND	4
OR	CANTON	HALBO		HCARE		96. CITY,	TOWN O	OR LOCATION OF D	EATH	9c. COU	CITY	
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY			10c, CITY	r, TOWN C	R LOCA	ION			10d. INSIDE CI	ITY
E	MD		CT	TY				RE CITY			LIMITS?	
	100. STREET AND NUMBER 3005 ELLIC			14.118			-	ZIP CODE	24	10g. CITI	IZEN OF WHAT COUNTRY U.S.A.	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 State Widowed 4 Dive	Married	12. WAS DECEDEN FORCES? 1	IT EVER IN U.S. AF	RMED NO	1	yes, sp	ENDENT OF HISPA	NIC ORIGIN? (Specify Yean, Puerto Rican, atc.)	or No-	14. RACE — American in Black, White, etc. Specify: WH.	
LETED	15. DEC (Specify on Elementary/Secondary (	CEDENT'S EDUC bly highest grade ( (6-12)	CATION completed) College (1-4 or 5	(G	CASH	vork done o e retired.)	CUPATION MO	ON st of working	16b. KIND OF BU			Ţ
COMPLET	17. FATHER'S NAME (First, A JOHN FOERTS				CASH	TEK			AME (First, Middle, Maiden	OD MA	RKET	
BE	19a. INFORMANT'S NAME (			100	h MAII ING	ADDRESS	(Street 6		RET REISIG	on Chata Tie	Codel	
2	JOHN MUSCH/							VENUE	BALTIMORE		YLAND 21224	4
	20a. METHOD OF DISPOSITION Burial 2 Crematic	on 3 - Remo	oval from State	20b. PLACE carnetery, cre	ematory or ot	har place)			1		City or Town, State	
	4 Donation 6 Other		ENSFF	DULANI	EA AV	LLEY	MEN	ORTAL (	KIL 15	MONTO	M, MARYLANI	<u> </u>
	1 len	Suo	12	und!						901 S.	21224 CONKLING ST.	
CERTIFICATION	Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (bleese or in) that initiated events resulting in death) LAS	ring ury	DUE TO	OR AS A CONSE	QUENCE OF	7):	5		usion		78	7
MEDICAL CER	PART II. Other algnifica		contributing to	death-but not	reaulting I	n the un	derlyin	g cause given in	Part I. 24a. WAS AN		24b. WERE AUTOPSY AMAILABLE PRIC	OT AC
ED									1 TYES	NO	OF DEATH?	
- 1	26 Who case are a	To Hemani T							1 D YES	NO NO		
- 1	25. WAS CASE REFERRED TEXAMINER? 1 YES 2 NO	PO- MEDICAL	HOSPITAL:	☐ ER/Outpatient :	B DOA	ОТНБЯ	26. PI	ACE OF DEATH (C	heck only one)	No No	OF DEATH?	
PHYSICIAN:	EXAMINER?  1  YES 2 NO  27. MANNER OF DEATH  1 Netural 6	Pending Investigation		INJURY	20b. TIMI	OTHER	26. Pi	ACE OF DEATH (C	1 D YES		OF DEATH? 1 YES 2	
ED BY PHYSICIAN:	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 6  2 Accident	Pending	1 Inpatient 2 26a. DATE OF (Month, D	INJURY	28b. TIMI	OTHER 4 Num E OF URY	26. Pl ing Hon 28c, IN. WC	ACE OF DEATH (C	heck only one)  6 Other (Specify)  28d, DESCRIBE HOW	NJURY OC	OF DEATH? 1 YES 2	
ETED BY PHYSICIAN: N	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 6   2 Accident 3 Suicide 6   4 Homicide  29a. CERTIFIER (Check only)	Pending Investigation Could not be determined	1 Inpetient 2 2 28a. DATE OF (Month, D 28a. PLACE C building, CIAN: To the best of	FINJURY Ley, Year)  OF INJURY — At his atc. (Specify)  If my knowledge, do	28b. TIMI INJ	OTHER 4 Munt E OF URY M	26. Pi	ACE OF DEATH (C  o 5 Residence URY AT RK7 /ES 2 NO  o  and place, and du	a to the cauce(a) and ma	and Number	OF DEATH?  1   YES 2    CURED  or or Rural Route Number,	□ №
O BE COMPLETED BY PHYSICIAN: N	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 6   2 Accident  3 Suicide 6   4 Homicide  29s. CERTIFIER 1 CERT (Check only one)  2 MED  29b. SIGNATURE NO TITLE	Pending Investigation Could not ba determined DICAL EXAMINET E OF PETTIFIER  A	28a. DATE OF (Month, D) 28a. PLACE OF building,  CIAN: To the best of a:  CAN: To the best of a:	F INJURY  Pey, Year)  OF INJURY — At he etc. (Specify)  If my knowledge, de examination and/or	28b. TIMI INJ ome, farm, s eath occurre investigatio	OTHER 4 Munt E OF URY M  Reet, fact	26. Pi	ACE OF DEATH (C  o 5   Residence URY AT RK? /ES 2   NO  o  and place, and du eath occured at the	to the cause(a) and mae time, date and place, as	and Number	OF DEATH?  1 YES 2 C  CURED  r or Rural Route Number,  ted.  te ceuse(a) and manner at	NO NO
O BE COMPLETED BY PHYSICIAN: N	EXAMINER?  1 YES 2 NO  27. MANNER OF BEATH  1 Netural 6   2 Accident  3 Suicide 6   4 Homicide  29a. CERTIFIER (Check only one) 2 MED	Pending Investigation Could not be determined TITIFYING PHYSIC DICAL EXAMINET E OF PERSON WHO	28a. DATE OF (Month, D. 28a. PLACE Of building, D. 28a. PLACE Of building, D. 28a. PLACE Of building, D. 28a. PLACE Of building, D. 28a. PLACE Of D. 28a. PLACE Of D. 28a. PLACE Of D. 28a. PLACE Of D. 28a. PLACE Of D. 28a. PLACE Of D. 28a. PLACE Of D. 28a. PLACE Of D. 28a. PLACE OF D. 28a. PLACE	F INJURY  Pey, Year)  OF INJURY — At he etc. (Specify)  If my knowledge, de examination and/or	28b. TIMI INJ ome, farm, s eath occurre investigatio	OTHER 4 Munt E OF URY M  Reet, fact	26. Pi	ACE OF DEATH (C  o 5   Residence URY AT RK? /ES 2   NO  o  and place, and du eath occured at the	to the cause(a) and mae time, date and place, as	and Number	OF DEATH?  1 YES 2 C  CURED  r or Bural Route Number,  ted.  he couse(a) and manner as	no no



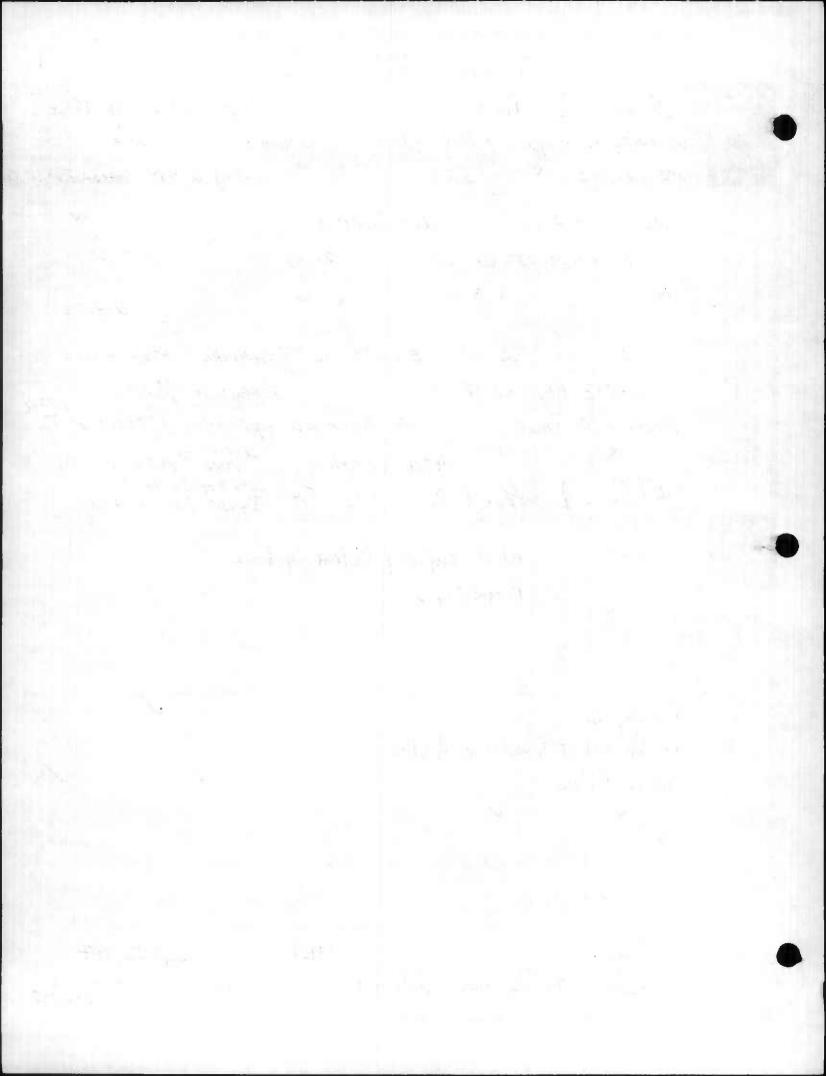
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month PRICE September /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) Examiner of Maryland Medical System Balfinore If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Days 193-34-5106 Usual Residanca of Decedent Director with the Meryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director GLEN BURNIE 10e. Street and Number 10g. Citizen of What Country? Examiner must be 208 CT. CIRCLE 21061 Funeral Pagas 1 and 2 should be filed within 72 hours after death nant of Haaith and Mentel Hygiena. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: "natural", or 1☐ Yes 2 No Àq WHITE 3 Widowed 4 Divorced Completed 7 is marked other than "natur treumstic event, tre Medical 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elementary/Secondary (0-12) ELECTRICAL TECHNICIAN 12 18. Mother's Name (First, Middle, Meiden Sui 17. Father's Name (First, Middla, Last) Be RAYMOND IRGINIA 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) /524/ 19a. Informant's Name/Ralationship (Type, Print) 20c. Location - City or Town, State

R. of Haaith a ltem 27 lt MIRGINIA Baltimore, 20e. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Placa of Disposition (Name of cametery, crematory or other place) Dete Department of Important: If It any Injury or o CREMATOR 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part1. Enter the disease or complications that caused the chath. Do not enter the mode of dying, such as cardiac or shock, or heart tailure. Let only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medicai Immadiate Cause (Final disease or condition resulting In death) Examiner Examiner physician and the burial-transit The law requires that the death certificete be executed Sequantially list conditions, if any, leading to Immadiate causa. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consequenca ot) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence ot) attanding pl signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Pancytogene Completed by 24b. Were autopsy findings evallable prior to completion of cause of death? Platelet Transfusion Reaction 24a. Was an autopsy performed? page 2 Kenal Failure 1 Yes certificeta Hospital or Attending Physician: 25. Was case reterred to medical axaminer?

1 Yes 2 No funeral director. 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Pinpatient 2 2 ER/Outpatient 3 DOA Shis 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 DNaturai 5 Pending Invastigation death. 1 ☐ Yas 2 ☐ No 2 Accidant efter death 3 Suicide 6 Could not be 28t. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify) Illed in by 4 Homleide To the Hospital within 24 hours e 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MW MD ess of person who complated causa ot daath (Item 23a) (Type, Print) TURNER 22 S Greene St. Baltimore, MD M.D. ot Medicine 21201-1595 31. Data tiled (Month, Dey, Year) State was Davids Registrar

OCT 151997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Got. 1:00 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth BLOOMSBE BALTI NORE

Winder 24 Hrs. 8. Dete of Birth
(Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1□M 200F 217-56-530 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BAUTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? BLOOMS BELLY ST.

atus

Married 2 Married

Med 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 DNo

If Yes, Give

Year or Dates: 21230 ) - 5 -13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritai Status Raca - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informent's Name/Relationship (Type, Print) BAUTIMORE BLOOM SALTIMOKE, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete Buriel 2 Cremetion 3 Removal from State CEM 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediete Cause (Final diseese or condition resulting in death) Obstructure Relmonan

**Physician** /Medical **Examiner** 

The law requires that the death certificate be executed

Physician/Medicai

Records, P.O. Box 68760,

Division of Vital

any injury

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

28a-f show

permit. Pages 1 end 2 should be filed within 72 hours after death with Department of Health end Mental Hygiene. Important: If item 27 is merked other than "natural", or itema 23e or

Baltimore, Maryland 21215-0020

Director

þ

Completed

Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

. 1 11 111 1

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

4,0

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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Completed	shaumotic bean	discoso				24a. Was en autopsy performed?	24b. Were autopsy findings evallable prior to completion of cause of death?
Be C	25. Was case referred to medical examiner?				26. Plece of De	eath (Check only one)	
9	1 ☐ Yes 2 ☑ No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Other: 4 Nursing	Home 5 Residence 6 □Ott	ner (Specify)
	27. Manner of Death  Natural 5 Pending  2 Accident investigat	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury et Work? 1 Yes 2 No	28d. Describe how Injury occur	red
Certification:	3 Suicide 6 Could not determine		nome, farm, street, fa	ctory, of	fice	28f. Location (Street and Number City or Town, State)	ber or Rural Route Number,
dical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	hysician: To the best of my known in the basis of exeminar: On the basis of exeminating end manner stated.	owledge, deeth occur etion and/or investiga	red et ti	ne time, date end pled my opinion, death occ	e, and due to the cause(s) and mourred at the time, date and place,	enner es stated. and due to the cause(a)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

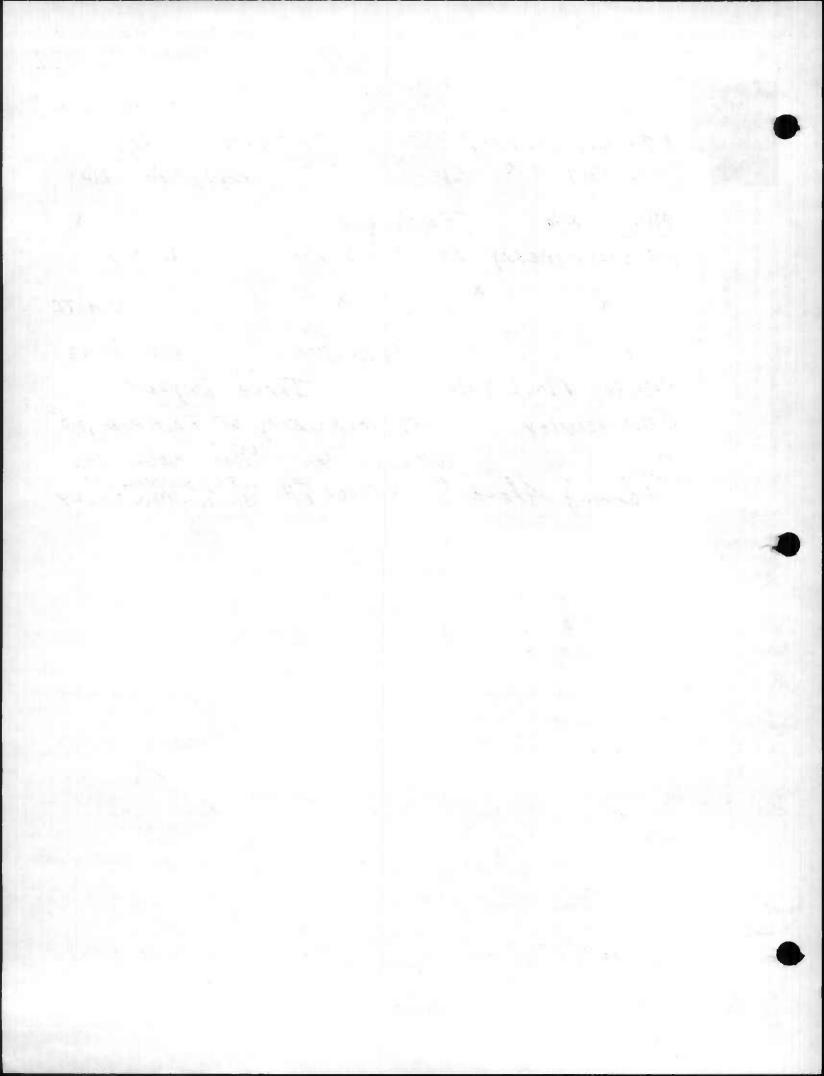
29d. Date signed (Month, Day, Year)

Registrar

29b. Signature and title of certifier

315 N. Colvert Street Boltman, MD 3. Registrar's Signature

29c. License number



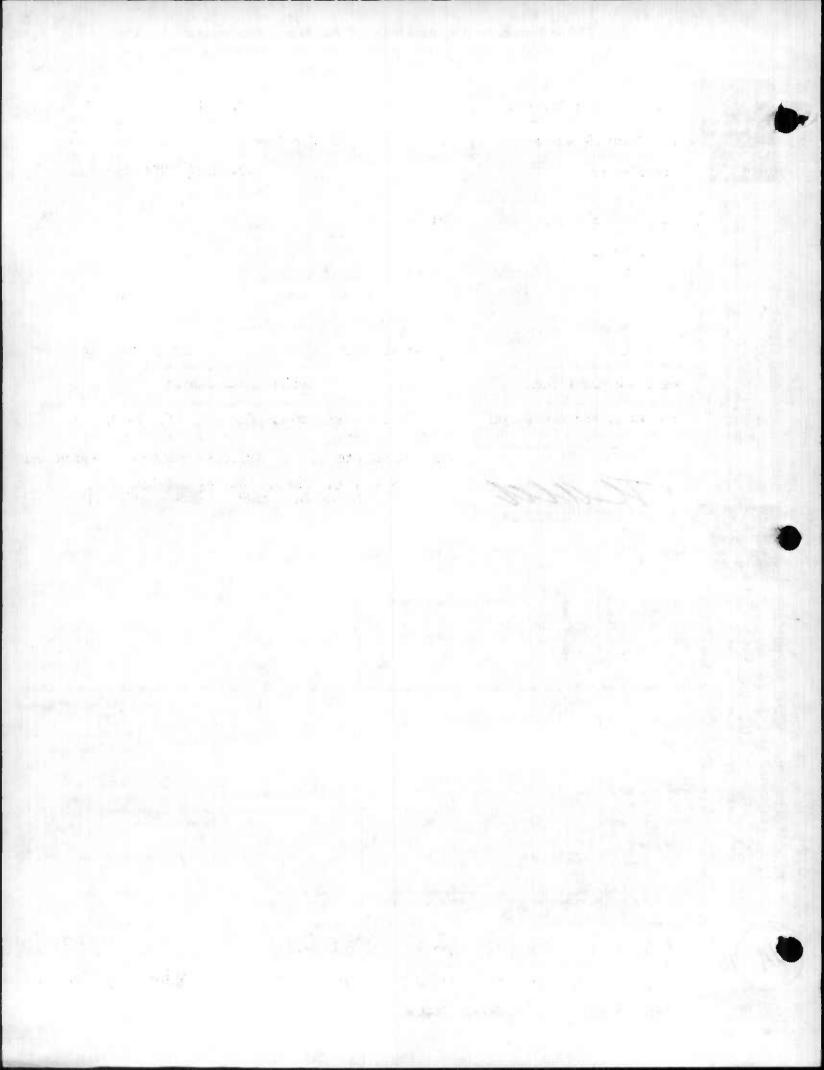
State of Maryland / Department of Health and Mental Hygiene 30993 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** HARRY HERBERT POZDENA Oct. 7, 1:20 a.m. /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 707 Burnside Drive Bel Air Harford Months Deys Hours Min. April 17, 1924 5. Social Security Number 7. Age (In vrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** 1 1 M 2 □ F Months 73 Yrs. 212-24-9806 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 707 Burnside Drive 21015 U.S.A. Funeral 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Meritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Year or Detes: 'natural', Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Buelness/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12th grade Accountant Steel Company is marked other permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Fether's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Henry Arthur Pozdena Helena Mary Tanner 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Sandra J. Pozdena (Wike) 707 Burnside Drive. Bel Air. MD. 20e. Method of Disposition 20b. Plece of Disposition (Neme of cometery, cremetory or other piece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Crametion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Othar (Specify) Green Mount Crematory 10/10/97 Baltimore. Maryland 22. Name end Address of Fecility
Schimunek Funeral Home of Bel Air, Inc.
210 (1) Mac Phail Road, Bel Air, MD. 21 21. Signetura of Funeral Service Licensee 21014 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Betw Physician /Medical Immediate Ceuse (Finel Cancer Months disease or condition resulting in deeth) Examiner Physician/Medical Examiner certificate be executed ding physician and use as the burial-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence ot): Box 68760. thet initieted events resulting in death) Lest Dua to (or es e consequance of) USB as The law requires that the death atter to P.O. 1 Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of deeth? 1 TYes 2 No 3⊠ Probably 4 ☐ Unknown Records, þ Completed 24b. Were eutopsy tindings availabla prior to completion of causa ot deeth? 24e. Was en eutopsy performed? page 2 1 Yes certificate 2 No 1 Yes 2 No Division of Vital Physician: Be 25. Wes case reterred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this the funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Yeer) Medical Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After or Attending 5 Pending investigetion 1 Neturel 1 Yes 2 No death 2 Accident 24 hours after deat Funeral Director: 3 Suicide 6 Could not be determined in by t 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end dua to the cause(s) and menner steted. 29e. Certifier tely 5 8 29b. Signature end title of pertifiar 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

31. Deta tiled (Month, Dey, Year) OCT 15 1997

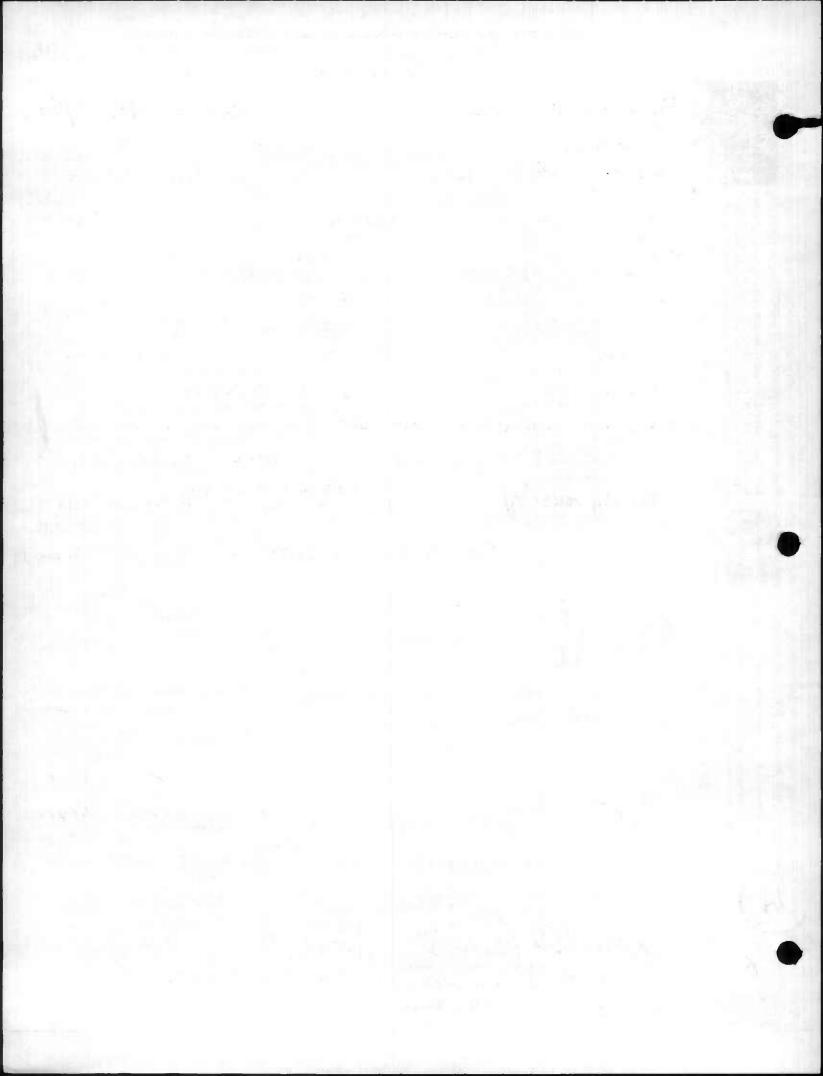
32. Registrer's Signature helia Tavidson-Randalle



State of Maryland / Department of Health and Mental Hygiene 97

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	6		30. Name end eddress of person who	completed cause	of death (Item 23e)	(Type, Print)			,	NN	11	1. 1	7. 21201
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State of Maryland / Department of Health and Mental Hygiene

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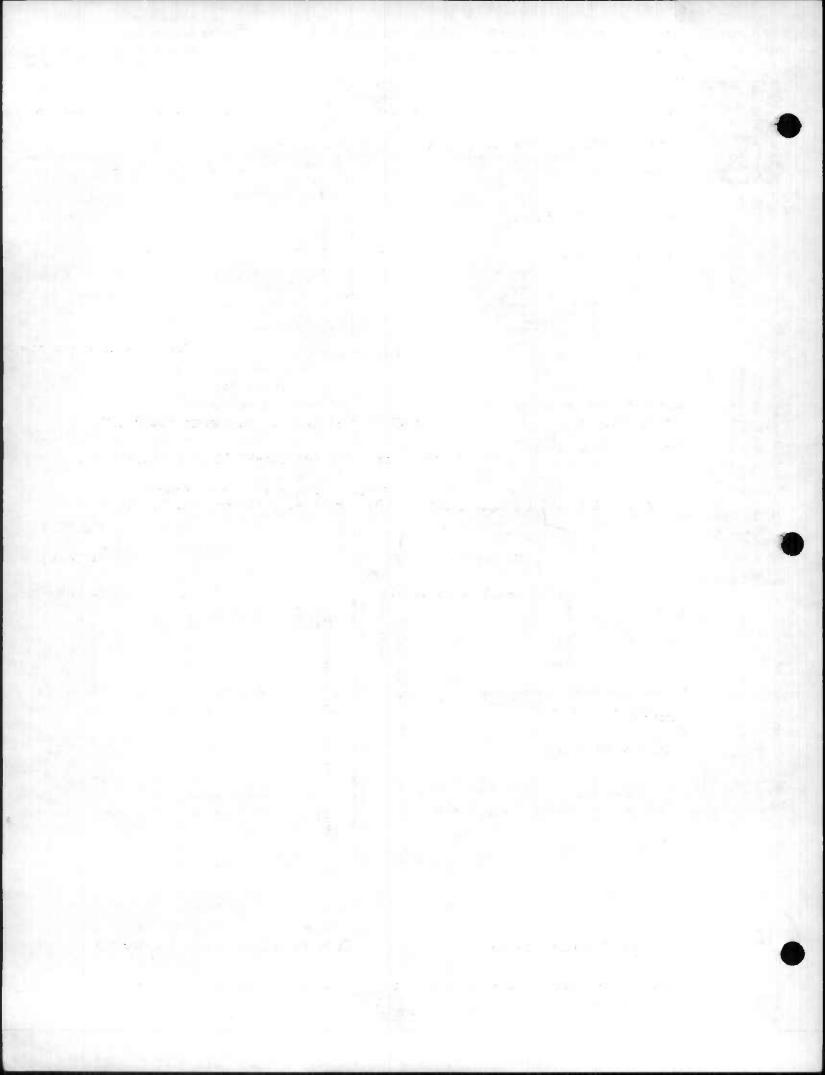
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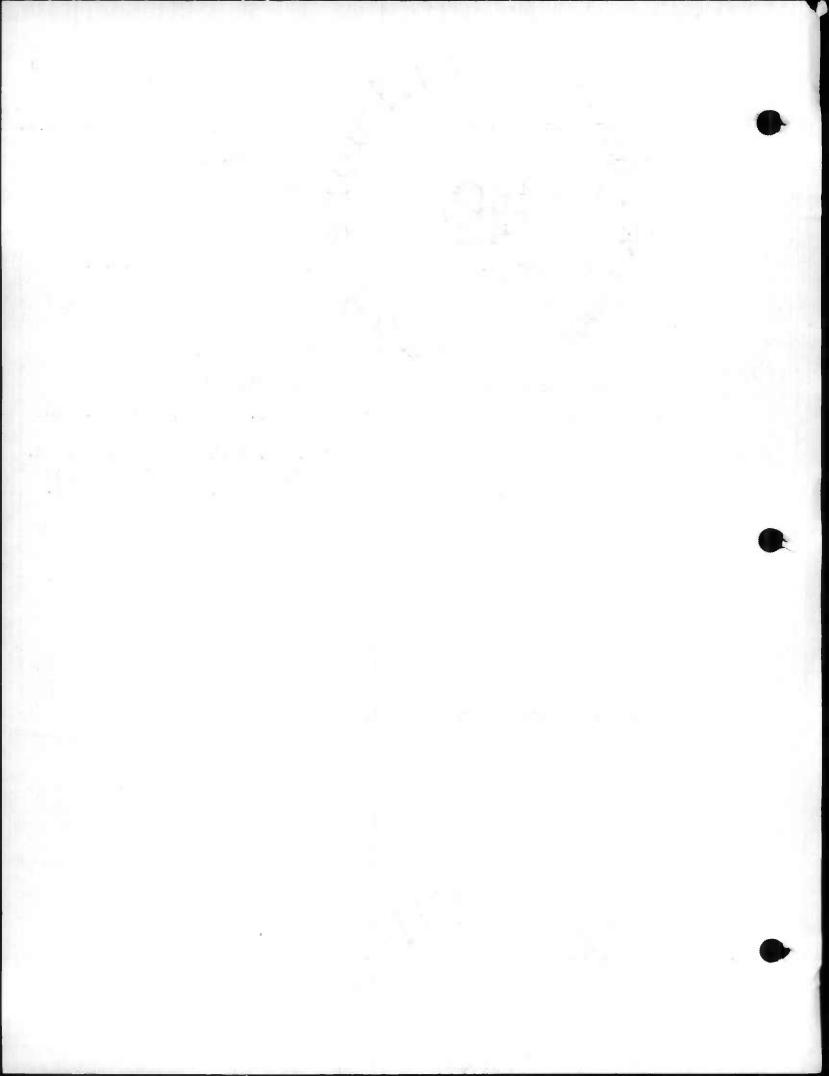
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	E HOSPITAL OR ATTENDING PHYSICIAN
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	4. SOCIAL SECURITY NUMBER 382-10-1973	5. 9EX 1 M 2 F	6. AGE (In yrs. 87		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH	8.	BIRTHPLACE (State or For Country) Texas	
TOR	9a. FACILITY NAME (If not institution, give Long View M	,	ome			or Location of D lester	DEATH		9c. COUNTY Ca	of DEATH rroll	
DIRECTOR	10a. STATE 10b. COUN	arroll		10c. CITY,	TOWN OR LOC Hamps					10d, INSIDE CITY LIMITS? V	
VERAL		sler Rd.			1	01. ZIP CODE 21074				S . A .	
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COMPL	17. FATHER'S NAME (First, Middle, Lest)  James M	urray Re	ed			16. MOTHER'S N.	AME (First Viol	Middle, Meiden	Surname)		
TO BE	19a. INFORMANT'S NAME (Type/Print) Judy Miller			3550°	poness (Street Water	Tank R	Goute Num	Manch	ester	, Md.211	02
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COMPL	29a. CERTIFIER 1 CERTIFYING PHY one) 2 MEDICAL EXAM									Buse(s) and manner as s	stated.
$\aleph$	29b. SIGNATURE AND TITLE OF CERTIFI	ER \	m	v		29c. LICENSE NU			29d. DATE SI	GNED (Month, Day, Year)	
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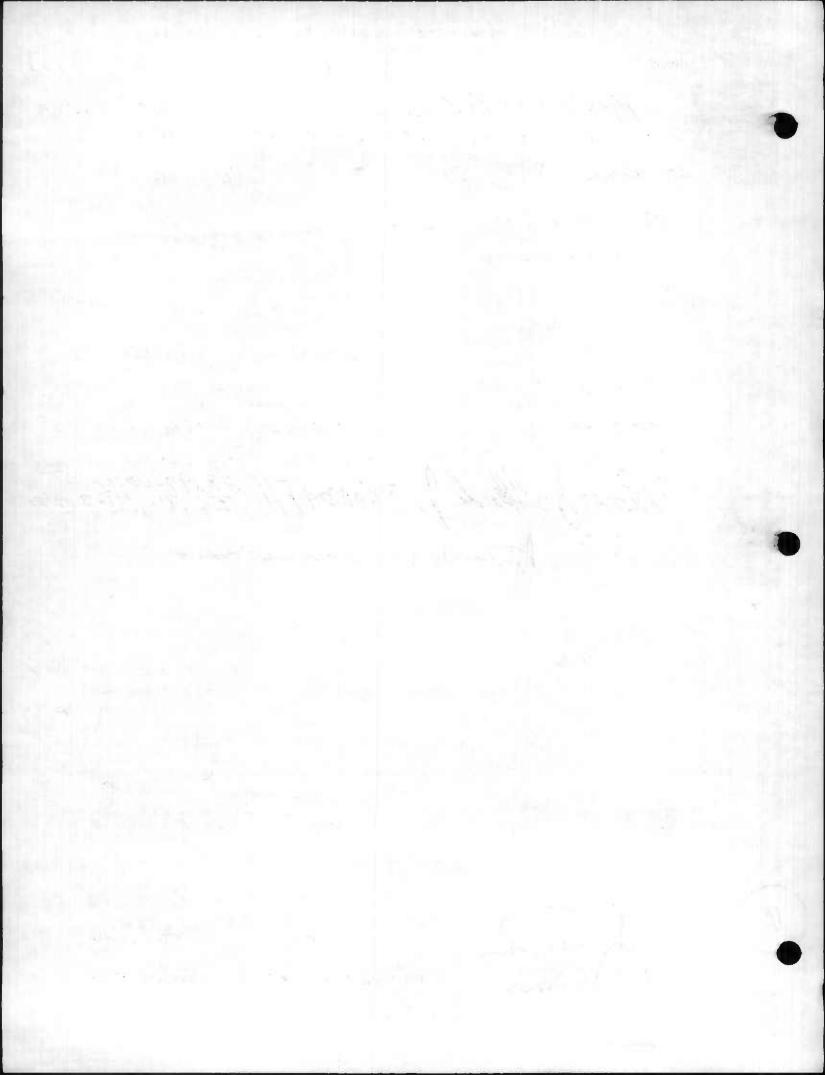
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29b. Signature an 29d. Data signed (Month, Day, Year) OCT . 5, 1997 29c. Licansa numbar O.C.M.E

30 Name and address Aperson who complated causa of death (item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Data filad (Month, Day, Yaar) 32. Registrar's Signatura OCT 1 5 1997



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 4:30p.M avid October 10,1997 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Balto Medical Center Dayview 7. Aga (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. Month, Day, Yeer) 5. Social Security Number Birthpleca (Steta or Foreign Country) 1**X** M 2□ F Z16-18-3281 Usuel Residence of Decedent January 1, 1922 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Md Turners 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 126 hut U.S.A 21222 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Merried 2 Married 1 ☐ Yas 2 No 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondapy (0-12) College (1-4or 5+) Trucker Transportation 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Malden Surneme) James 1-1009 ce 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Wife 126 Balto, Md. 21222 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta Dete 1 Buriel 2 Cremetion 3 Removal from State Cem. Connection 5 ☐ Other (Specify) Parkwood 10 15 Baltimore Md 22. Name end Address of Facility + Sons A. Morton James Balto, Md. St. 1701 Laurens 212-17 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, or heart feiture. List only one cause on each line. Approximata Intervel Between Onset and Deeth Immediate Cause (Finel disaasa or condition resulting in deeth) vascular disease COKOHOK Due to (or es e consequence of): sizon siz Sequentielly list conditions, if eny, leeding to Immediate causa. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in deeth) Last Due to (or es e consequenca of): lension me 1 Pert II. Other significant conditions contributing to death but not resulting in the undarfying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? Svillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 1 □ Yas 30 No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify)

**Physician** /Medical Examiner

pernit. Pages 1 and 2 should be filed within 72 hours efter death with to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural;, or Itema 23a or any Injury or other traumatic event, the Magical Examine must be no

Maryland 21215-0020

Baltimore,

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

ò

Completed

Be

**Funeral** 

Director

the Maryland r 28a-f show

> the buriel-tran physician for use as page 2 this certificate

Examiner by Physician/Medical Completed funeral director, Medical Certification: To After 24 hours efter death. Funeral Director: Al filled in by

or Attending Physician: The law requires that the death certificete be executed

Hospital

0

Box 68760,

Division of Vital Records, P.O.

5 Pending investigation

6 Could not be

28e. Dete of Injury (Month, Dey Year) 28e. Pieca of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how Injury occurred

Blud, Ste 724, Belt. MO ZIZZ4

28f. Location (Streat and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

27. Menner of Deeth

1 Netural

2 Accident

3 Suicide

4 Thomicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) end menner as steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pieca, end dua to the cause(s) end manner stated.

29b. Signeture end title of certifige

M.O.

29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print).

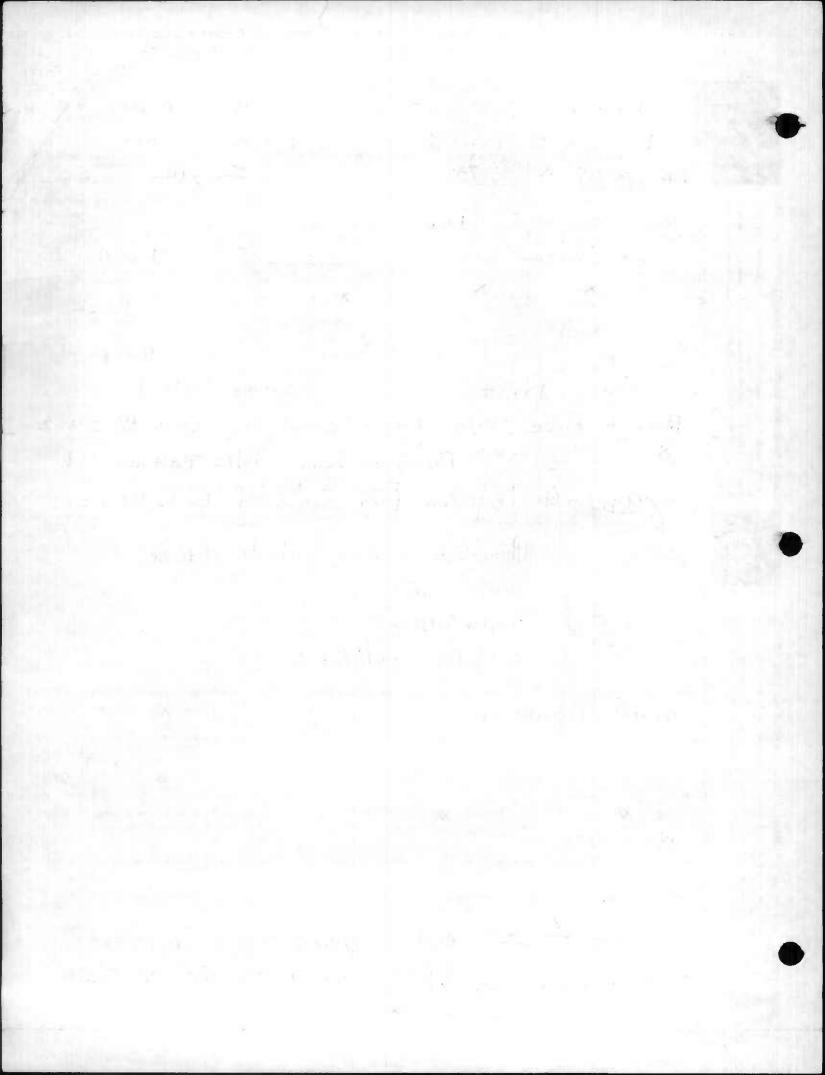
Theodore A, Stephens 1005 World Point 31. Dete filed (Month, Day, Year)

OCT 1 5 1997

. Pegistrar's Signeture

Registrar **DHMH 16 Rav 6/95** 

State



State of Maryland / Department of Health and Mental Hygiene

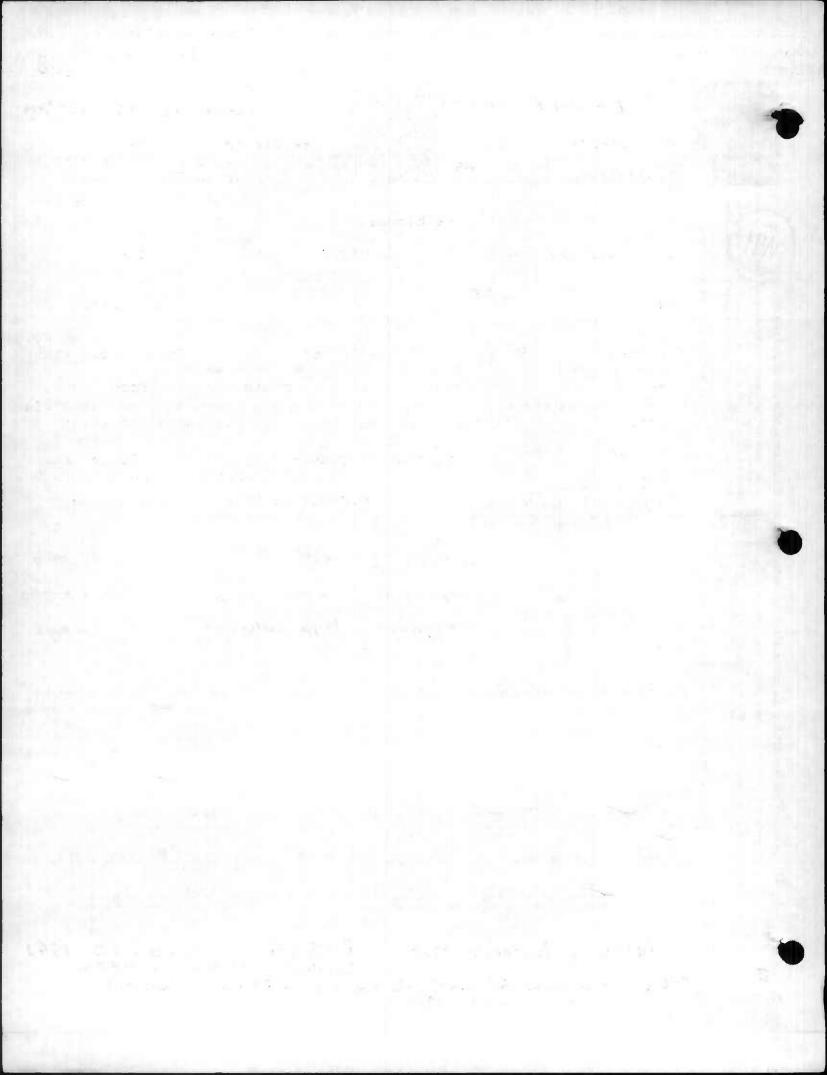
Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death **Physician** Month LARRY R. SMOOT october 12 /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore 7. Age (In yrs. last birthday) 58 yrs. If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 1**⊠** M 2□ F Director 216-34-2396 SC 09-16-39 Usual Rasidance of Dacedant 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Yas 2□No Director Md NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 1124 Halstead Road 21234 USA Funeral 12. Was Decadant Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. 1 Navar Married 2 Married 1 Yes 2 No If Yas, Give Year or Datas: 1 Yes XX No Specify: þ Specify: 3€Widowed 4 Divorced Black Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Dacedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry the Me Co. Elamentary/Secondary (0-12) 6th Grade College (1-4or 5+) Truck Driver Union Bros. Fish 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) 12 should be fit in and Mental H I is marked oth T.eo Smoot Mamie eges 1 and 2 sh. important of Health and 8. any injury or other 27 is present 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 21234 19a. Informant's Name/Relationship (Type, Print) Mamie Williams 1124 Halstead Road Baltimore, Maryland Baltimore, 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramovai from State Greenmount Cemetery 10-17-97 Baltimore, Md. 4 □ Donation 5 □ Othar (Specify) 21. Signature of Funaral Service Licensina Baltimore, Maryland 21202 22. Nama and Addrass of Facility WM.C.March FH 1101 E, North Avenue 23a. Partī. Entar tha disaasa, or complications that causad the death. Do not antar tha mode of dylng, such as cardiac or raspiratory arrest, shock, or haart failure. List only one causa on each line. Approximate Interval Batwaan Onsat and Daeth **Physician** /Medical Immediata Cause (Finel disaasa or condition rasulting in daath) 20 min ardiac Examiner Dua to (or as a consequence of): Esophaceal
Dua to (or es a consequance of): 1-2 months Sequentially list conditions, if any, laeding to immadiate causa. Entar Undarlying Ceusa (Disaasa or Injury that initieted avents rasulting in death) Last Hyper calcemia Bud physician esthe buriel-Box 68760. Malignant 3 days Physician/Medical Dua to (or as a consequenca of): ettending 0 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? P.O. signed by t 1 | Yee 2 No 3 | Probably 4 | Unknown Records, by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of deeth? Completed 1 Yas 2 No 1 Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Wes casa rafarrad to madical axaminer?

1 Yes Property No. Be 26. Place of Deeth (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Deeth 28b Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding Natural 1 ☐ Yas 2 ☐ No 2 Accident Invastigation 6 Could not be datamined 3 ☐ Sulcida Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Cartifying Physician: To the best of my knowledga, daath occurrad at tha tima, date end place, and dua to tha causa(s) and mannar as stated. Medical 29a. Certifiar 2 Medicat Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the tima, deta and place, and dua to the cause(s) and manner stated. (Check only one) 29b. Signature and titla of cartifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) AdniaNa Andrade, mp P10579 October 12 30. Nama and address of person who complated causa of daath (Item 23e) (Type, Print) Baltimore, Managed - 21237. THE GOOD SAMARITAN HOSPITAL #5601 LOCH RAVEN BOULEVARD

31. Data filed (Month, Day, Year) 32 Register's SIGNATURE 31. Data filed (Month, Day, Year) OCT 1 5 1997 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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ledical aminer	46	Facility Name (If not institution, g	giva street a	and number)				4b. City, Town, or L	ocation of Death	4c. County		
	Ŀ	Union MEn	1 +	JOSP				Baltimo	re		NA	
tor		Social Security Number 220-22-3081  sual Residence of Dacedant	Sax 1□M 24		in yrs. last b		er 1 Yea s Days	H Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day 11-09-	Year) -27	9. Birthpla Country NC	ca (State or Foreign y)
	-	Da. Stata 10b. County		10	Oc. City, To	wn or Location					100	d. Inside City Limits
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Director	10	De. Street end Number				10f. 2	ip Coda		1	0g. Citizen of	What Country	y?
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